

Facility Name & ID Number NEW ATHENS HOME FOR THE AGED

0033043 Report Period Beginning: 1/1/10 Ending: 12/31/10

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 4-18-2007

	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	37	Skilled (SNF)	37	13,505	1
2		Skilled Pediatric (SNF/PED)			2
3	16	Intermediate (ICF)	16	5,840	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	53	TOTALS	53	19,345	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	0	0	825	825	8	
9	SNF/PED					9	
10	ICF	10,716	2,712	1,293	14,721	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	10,716	2,712	2,118	15,546	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.36%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

PODIATRY, MEALS, FLU SHOTS

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 1/1/1968

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 37 and days of care provided 825

Medicare Intermediary NATIONAL GOVERNMENTS SERVICES (NGS)

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 1/1/2010 Fiscal Year: 12/31/2010

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	133,541			133,541	6,421	139,962		139,962		1
2	Food Purchase		92,067		92,067		92,067		92,067		2
3	Housekeeping	41,969	7,581		49,550		49,550		49,550		3
4	Laundry	67,732	9,676		77,408		77,408		77,408		4
5	Heat and Other Utilities			69,111	69,111		69,111		69,111		5
6	Maintenance	17,040	26,076		43,116		43,116		43,116		6
7	Other (specify):* KITCHEN SUPPLIES		10,092		10,092		10,092		10,092		7
8	TOTAL General Services	260,282	145,492	69,111	474,885	6,421	481,306		481,306		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	612,089	157,373		769,462	22,620	792,082		792,082		10
10a	Therapy	13,683			13,683	745	14,428		14,428		10a
11	Activities	33,706	6,339		40,045	858	40,903		40,903		11
12	Social Services	17,456			17,456	2,572	20,028		20,028		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* CARE PLAN COOR	36,668		38,150	74,818	(33,216)	41,602		41,602		15
16	TOTAL Health Care and Programs	713,602	163,712	38,150	915,464	(6,421)	909,043		909,043		16
	C. General Administration										
17	Administrative	58,714			58,714		58,714		58,714		17
18	Directors Fees										18
19	Professional Services			4,530	4,530		4,530		4,530		19
20	Dues, Fees, Subscriptions & Promotions			5,281	5,281		5,281		5,281		20
21	Clerical & General Office Expenses	36,434	12,876	3,997	53,307		53,307		53,307		21
22	Employee Benefits & Payroll Taxes			167,998	167,998		167,998		167,998		22
23	Inservice Training & Education			1,583	1,583		1,583		1,583		23
24	Travel and Seminar			2,252	2,252		2,252		2,252		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			46,728	46,728		46,728		46,728		26
27	Other (specify):* FINES			4,945	4,945		4,945	(4,945)			27
28	TOTAL General Administration	95,148	12,876	237,314	345,338		345,338	(4,945)	340,393		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,069,032	322,080	344,575	1,735,687		1,735,687	(4,945)	1,730,742		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			58,526	58,526		58,526		58,526		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			75	75		75		75		32
33	Real Estate Taxes			7,216	7,216		7,216	(7,216)			33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	TOTAL Ownership			65,817	65,817		65,817	(7,216)	58,601		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			29,018	29,018		29,018		29,018		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers			29,018	29,018		29,018		29,018		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,069,032	322,080	439,410	1,830,522		1,830,522	(12,161)	1,818,361		45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	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				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	(4,945)			18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				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 REAL ESTATE TAX	(7,216)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (12,161)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (12,161)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

NEW ATHENS HOME FOR THE AGED

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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

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
ILLINOIS SOUTH CONFERENCE OF THE UNITED CHURCH OF CHRIST	100%					

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	N/A	\$			\$	\$	1
2	V							2
3	V							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		\$			\$	\$ *	14

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

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

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

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

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VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number

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IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6		8	9	10									
					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						\$	\$			\$	1							
2											2							
3											3							
4											4							
5											5							
Working Capital																		
6	THE VILLAGE BANK		WORKING CAPITAL LOC		02/17/10			2/17/11	8.0000	75	6							
7											7							
8											8							
9	TOTAL Facility Related					\$	\$			\$ 75	9							
B. Non-Facility Related*																		
10											10							
11											11							
12											12							
13											13							
14	TOTAL Non-Facility Related					\$	\$			\$	14							
15	TOTALS (line 9+line14)					\$	\$			\$ 75	15							

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

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

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

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME NEW ATHENS HOME FOR THE AGED COUNTY ST. CLAIR

FACILITY IDPH LICENSE NUMBER 0033043

CONTACT PERSON REGARDING THIS REPORT GARY HOLTGREWE

TELEPHONE 618-457-2550 FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(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? X YES _____ NO

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

C. Tax Bills

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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.**

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X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 18,230 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>NURSING HOME</u>	<u>40,260</u>	<u>1952</u>	<u>\$ 20,000</u>	<u>1</u>
2	<u>ADJACENT LOT</u>	<u>7,500</u>	<u>1986</u>	<u>7,000</u>	<u>2</u>
3	TOTALS	47,760		\$ 27,000	3

Facility Name & ID Number **NEW ATHENS HOME FOR THE AGED**# **0033043**

Report Period Beginning:

1/1/10

Ending:

12/31/10**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	11			1957	\$ 223,618	\$		\$		\$ 223,618	4
5	31			1970	320,925	8,023		8,023		307,290	5
6	11			1979	53,990	1,350		1,350		42,517	6
7				1980	97,177	2,429		2,429		74,097	7
8											8
	Improvement Type**										
9	GENERAL			1966	10,431					10,431	9
10	GENERAL			1967	6,088	30		30		6,088	10
11	GENERAL			1968	4,183	104		104		4,183	11
12	GENERAL			1972	6,897	173		173		6,415	12
13	GENERAL			1973	13,854	346		346		12,606	13
14	GENERAL			1974	4,682	117		117		4,167	14
15	GENERAL			1975	14,081	352		352		12,251	15
16	GENERAL			1976	21,994	550		550		18,696	16
17	GENERAL			1978	2,886	72		72		2,337	17
18	GENERAL			1982	4,197	105		105		2,990	18
19	GENERAL			1983	34,509	863		863		23,725	19
20	GENERAL			1984	26,999	675		675		17,887	20
21	GENERAL			1985	43,436	1,086		1,086		27,691	21
22	GENERAL			1986	72,596	1,815		1,815		44,465	22
23	GENERAL			1987	12,434	311		311		7,305	23
24	GENERAL			1990	37,580	940		940		19,259	24
25	GENERAL			1991	128,213	3,205		3,205		62,504	25
26	GENERAL			1992	52,056	1,301		1,301		24,076	26
27	GENERAL			1993	2,808	70		70		1,228	27
28	GENERAL			1994	18,866	416		416		9,101	28
29	GENERAL			1995	4,122	106		106		1,639	29
30	FOUNDATION REPAIRS			1996	15,640	401		401		5,815	30
31	KITCHEN RENOVATIONS			2001	595,899	14,897		14,897		148,974	31
32	KITCHEN RENOVATIONS			2002	44,811	1,120		1,120		9,522	32
33	DINING ROOM RENOVATIONS			2003	3,029	76		76		600	33
34	DAMPERS			2003	930	23		23		174	34
35	A/C UNITS			2003	3,968	198		198		835	35
36	ARCHITECT FEES			2005	4,400	110		110		568	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

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0033043

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1/1/10

Ending:

12/31/10

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	ROOF REPAIR	2005	\$ 1,800	\$ 180		\$ 180		\$ 368	37
38	CONCRETE PAD	2006	16,700	418		418		1,810	38
39	HALL FLOORING	2006	3,952	99		99		420	39
40	NEW DECK & COURTYARD	2006	23,121	578		578		2,312	40
41	ENLARGE DOORWAY	2007	1,199	30		30		117	41
42	HOT WATER HEATER	2007	7,574	189		189		694	42
43	LIGHT FIXTURES	2007	548	27		27		55	43
44	LANDSCAPE	2007	2,408	120		120		381	44
45	CARPET	2007	1,406	94		94		194	45
46	3 A/C UNITS	2007	5,174	345		345		614	46
47	LIGHT FIXTURES	2008	663	33		33		63	47
48	APARTMENT CARPET	2009	1,678	112		112		137	48
49	ROOF	2009	30,570	3,057		3,057		3,439	49
50	2 A/C UNITS	2009	1,113	74		74		83	50
51	4 A/C UNITS	2009	2,310	154		154		193	51
52	80 GALLON WATER HEATER	2010	5,980	125		125		125	52
53	HAND RAIL ON RAMP	2010	7,525	63		63		63	53
54	2 ELECTRIC PANELS	2010	3,375	14		14		14	54
55	SPRINKLER SYSTEM	2010	5,500	12		12		12	55
56	AC UNIT	2010	1,595	62		62		62	56
57	2 AC UNITS	2010	1,303	36		36		36	57
58	DOOR CLOSERS	2010	727	16		16		16	58
59	3 AC UNITS	2010	5,725	127		127		127	59
60	GENERATOR	2010	17,523						60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,036,768	\$ 47,229		\$ 47,229		\$ 1,144,389	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 56,725	\$ 6,080	\$ 6,080	\$		\$ 24,806	71
72	Current Year Purchases	26,457	1,940	1,940			1,940	72
73	Fully Depreciated Assets	363,153	3,277	3,277			363,153	73
74								74
75	TOTALS	\$ 446,335	\$ 11,297	\$ 11,297	\$		\$ 389,899	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,510,103	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 58,526	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 58,526	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)	\$ 1,534,288	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	6 ASSISTED LIVING UNITS	\$ 253,710	\$ 6,343	\$ 121,569	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 253,710	\$ 6,343	\$ 121,569	91

G. Construction-in-Progress

	Description	Cost	
92	CONSTRUCTION IN PROG	\$ 3,800	92
93			93
94			94
95		\$ 3,800	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NONE

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

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: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____ /2011 \$ _____

13. _____ /2012 \$ _____

14. _____ /2013 \$ _____

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		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	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/10**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 300,604	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	180,722		3
4	Supply Inventory (priced at)	9,186		4
5	Short-Term Investments	2,100		5
6	Prepaid Insurance	11,203		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 503,815	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	27,000		13
14	Buildings, at Historical Cost	2,294,279		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	446,335		16
17	Accumulated Depreciation (book methods)	(1,655,857)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,111,757	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,615,572	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 44,457	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,450		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	44,533		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			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)	\$ 91,440	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 91,440	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,524,132	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,615,572	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,443,335	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,443,335	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	80,797	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)	\$ 80,797	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,524,132	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number NEW ATHENS HOME FOR THE AGED

0033043

Report Period Beginning: 1/1/10

Ending: 12/31/10

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	\$ 1,829,550	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,829,550	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,357	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,357	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		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)	\$	23
D. Non-Operating Revenue			
24	Contributions	55,426	24
25	Interest and Other Investment Income***	1,373	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 56,799	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	NET RENTAL INCOME	23,613	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 23,613	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,911,319	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	474,885	31
32	Health Care	915,464	32
33	General Administration	345,338	33
B. Capital Expense			
34	Ownership	65,817	34
C. Ancillary Expense			
35	Special Cost Centers	29,018	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,830,522	40
41	Income before Income Taxes (line 30 minus line 40)**	80,797	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 80,797	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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.

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

Facility Name & ID Number **NEW ATHENS HOME FOR THE AGED**

0033043

Report Period Beginning:

1/1/10

Ending:

12/31/10

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	1,828	1,988	\$ 53,621	\$ 26.97	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,825	1,857	40,941	22.05	3
4	Licensed Practical Nurses	12,443	12,731	215,335	16.91	4
5	CNAs & Orderlies	28,754	29,794	302,192	10.14	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,177	1,209	13,683	11.32	8
9	Activity Director	2,040	2,208	33,706	15.27	9
10	Activity Assistants					10
11	Social Service Workers	1,268	1,492	17,456	11.70	11
12	Dietician					12
13	Food Service Supervisor	1,313	1,937	30,420	15.70	13
14	Head Cook	2,807	3,015	29,398	9.75	14
15	Cook Helpers/Assistants	2,906	3,258	32,722	10.04	15
16	Dishwashers	3,938	4,418	41,001	9.28	16
17	Maintenance Workers	1,435	1,475	17,040	11.55	17
18	Housekeepers	4,240	4,624	41,969	9.08	18
19	Laundry	5,763	6,443	67,732	10.51	19
20	Administrator	1,848	2,080	58,714	28.23	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,832	2,080	36,434	17.52	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) CARE PLAN COO	1,779	2,107	36,668	17.40	33
34	TOTAL (lines 1 - 33)	77,196	82,716	\$ 1,069,032 *	\$ 12.92	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	100	\$ 6,421	35
36	Medical Director	12	6,000	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	48	2,211	39
40	Physical Therapy Consultant	12	745	40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	24	858	44
45	Social Service Consultant	72	2,572	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	268	\$ 18,807	49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	0	\$ 0	50
51	Licensed Practical Nurses	182	6,602	51
52	Certified Nurse Assistants/Aides	385	7,807	52
53	TOTAL (lines 50 - 52)	567	\$ 14,409	53

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	
GARY HOLTGREWE	ADMINISTRATOR		\$ 58,714	Workers' Compensation Insurance	\$ 77,350	IDPH License Fee	\$	
				Unemployment Compensation Insurance	4,792	Advertising: Employee Recruitment	3,488	
				FICA Taxes	80,837	Health Care Worker Background Check		
				Employee Health Insurance	2,244	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks	1,793	
				Illinois Municipal Retirement Fund (IMRF)*				
				Uniforms	2,775			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 58,714					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount				Less: Public Relations Expense ()	
			\$				Non-allowable advertising ()	
							Yellow page advertising ()	
							TOTAL (agree to Sch. V, line 20, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				\$ 5,281	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
MOORE, RENNER & SIMONIN	AUDIT		\$ 4,530			\$	Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	2,252
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 4,530	TOTAL			(agree to Sch. V, line 24, col. 8)	
							TOTAL	
							\$ 2,252	

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number NEW ATHENS HOME FOR THE AGED# 0033043Report Period Beginning: 1/1/10Ending: 12/31/10**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ N/A Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 29,018
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: MOORE, RENNER & SIMONIN, P.C.
- (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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

NEW ATHENS HOME FOR THE AGED
SCHEDULE OF RECLASSIFICATIONS ON PAGES 3&4
2010

	LINE #		
DIETARY	1	6,421	
NURSING AND MEDICAL RECORDS	10	22,620	
THERAPY	10a	745	
ACTIVITIES	11	858	
SOCIAL SERVICES	12	2,572	
OTHER	15		33,216