

Facility Name & ID Number Swann Special Care Center

0035485 Report Period Beginning: 7/1/09 Ending: 6/30/10

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 N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2	<u>123</u>	Skilled Pediatric (SNF/PED)	<u>123</u>	<u>44,895</u>	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>123</u>	TOTALS	<u>123</u>	<u>44,895</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED	<u>41,822</u>	<u>730</u>	<u>0</u>	<u>42,552</u>	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>41,822</u>	<u>730</u>		<u>42,552</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.78%

D. How many bed-hold days during this year were paid by the Department? 678 (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 8/15/89

J. Was the facility purchased or leased after January 1, 1978?
YES Date 8/15/89 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: 6/30/10 Fiscal Year: 6/30/10

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

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 7/1/09 Ending: 6/30/10

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	241,424	17,186	20,311	278,921	14,180	293,101	(69,103)	223,998		1
2	Food Purchase		266,441		266,441		266,441		266,441		2
3	Housekeeping		36,938	142,866	179,804		179,804		179,804		3
4	Laundry	32,282	11,287	100,454	144,023		144,023		144,023		4
5	Heat and Other Utilities			84,619	84,619	1,362	85,981		85,981		5
6	Maintenance	58,251	9,845	60,005	128,101	18,422	146,523		146,523		6
7	Other (specify):*										7
8	TOTAL General Services	331,957	341,697	408,255	1,081,909	33,964	1,115,873	(69,103)	1,046,770		8
	B. Health Care and Programs										
9	Medical Director			36,800	36,800		36,800		36,800		9
10	Nursing and Medical Records	2,755,432	211,029	10,685	2,977,146	4,864	2,982,010		2,982,010		10
10a	Therapy	47,314	3,023	140,497	190,834		190,834		190,834		10a
11	Activities	204,356	668	1,336	206,360	(1,020)	205,340		205,340		11
12	Social Services	2,961	37	2,494	5,492		5,492		5,492		12
13	CNA Training					21,064	21,064		21,064		13
14	Program Transportation	58,175	915	13,512	72,602		72,602		72,602		14
15	Other (specify):* Ward Clerk	18,084			18,084		18,084		18,084		15
16	TOTAL Health Care and Programs	3,086,322	215,672	205,324	3,507,318	24,908	3,532,226		3,532,226		16
	C. General Administration										
17	Administrative	64,742		265,803	330,545	(242,616)	87,929	(23,187)	64,742		17
18	Directors Fees					24,620	24,620		24,620		18
19	Professional Services			659,862	659,862	91,663	751,525		751,525		19
20	Dues, Fees, Subscriptions & Promotions			17,980	17,980	440	18,420	(6,426)	11,994		20
21	Clerical & General Office Expenses	143,922	13,337	70,194	227,453	54,321	281,774	(20)	281,754		21
22	Employee Benefits & Payroll Taxes			740,014	740,014	13,948	753,962		753,962		22
23	Inservice Training & Education										23
24	Travel and Seminar			15,424	15,424	(1,852)	13,572	(391)	13,181		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			63,736	63,736		63,736		63,736		26
27	Other (specify):* Bad Debt			103,905	103,905		103,905	(103,905)			27
28	TOTAL General Administration	208,664	13,337	1,936,918	2,158,919	(59,476)	2,099,443	(133,929)	1,965,514		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,626,943	570,706	2,550,497	6,748,146	(604)	6,747,542	(203,032)	6,544,510		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.

Facility Name & ID Number Swann Special Care Center

#0035485

Report Period Beginning:

7/1/09

Ending:

6/30/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			205,132	205,132	210	205,342		205,342			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			472,928	472,928	14,743	487,671	(86,079)	401,592			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds					2,252	2,252		2,252			34
35	Rent-Equipment & Vehicles			9,859	9,859	(94)	9,765		9,765			35
36	Other (specify):* Amortization			41,239	41,239		41,239	(30,315)	10,924			36
37	TOTAL Ownership			729,158	729,158	17,111	746,269	(116,394)	629,875			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			415,529	415,529		415,529		415,529			42
43	Other (specify):* Edu/Day Training	1,139,731	8,559	316,518	1,464,808	(16,507)	1,448,301		1,448,301			43
44	TOTAL Special Cost Centers	1,139,731	8,559	732,047	1,880,337	(16,507)	1,863,830		1,863,830			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,766,674	579,265	4,011,702	9,357,641		9,357,641	(319,426)	9,038,215			45

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

Facility Name & ID Number Swann Special Care Center

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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	1,126	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				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(103,905)	27		24
25	Fund Raising, Advertising and Promotional	(6,191)	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	(187,269)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (296,239)		\$	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)	(23,187)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (23,187)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (319,426)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

Swann Special Care Center

ID# 0035485

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Ending: 6/30/10

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Non-patient meals	\$ (69,103)	1	1
2	Amortization - Goodwill	(27,835)	36	2
3	Non-Allowable Bond Acquisition Costs	(2,480)	36	3
4	Non-Allowable Interest Expense	(87,205)	32	4
5	Non-Allowable Travel	(391)	24	5
6	Non-Allowable Dues	(235)	20	6
7	Miscellaneous Income	(20)	21	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	(187,269)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Swann Special Care Center# 0035485

Report Period Beginning:

7/1/09

Ending:

6/30/10

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(69,103)	0	0	0	0	0	0	0	0	0	0	(69,103)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(69,103)	0	0	0	0	0	0	0	0	0	0	(69,103)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(23,187)	0	0	0	0	0	0	0	0	0	(23,187)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(6,426)	0	0	0	0	0	0	0	0	0	0	(6,426)	20
21	Clerical & General Office Expenses	(20)	0	0	0	0	0	0	0	0	0	0	(20)	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	(391)	0	0	0	0	0	0	0	0	0	0	(391)	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):*	(103,905)	0	0	0	0	0	0	0	0	0	0	(103,905)	27
28	TOTAL General Administration	(110,742)	(23,187)	0	(133,929)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(179,845)	(23,187)	0	(203,032)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Swann Special Care Center# 0035485

Report Period Beginning:

7/1/09

Ending:

6/30/10

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
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	(86,079)	0	0	0	0	0	0	0	0	0	0	(86,079)	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):*	(30,315)	0	0	0	0	0	0	0	0	0	0	(30,315)	36
37	TOTAL Ownership	(116,394)	0	0	0	0	0	0	0	0	0	0	(116,394)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(296,239)	(23,187)	0	0	0	0	0	0	0	0	0	(319,426)	45

Facility Name & ID Number

Swann Special Care Center

0035485

Report Period Beginning:

7/1/09

Ending:

6/30/10

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			
		Vernon Manor Children's Home	Wabash, Indiana			
		Walter Lawson Children's Home	Loves Park			
		Richland-Bean Blossom HCC	Ellettsville, Indiana			
		Exceptional Living Centers of Brazil	Brazil, 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	\$ 265,803	Hoosier Care, Inc.	100.00%	\$ 242,616	\$	(23,187)
2	V							
3	V			Note: See Schedule VIII of allocation of cost per column 7.				
4	V							
5	V							
6	V							
7	V							
8	V							
9	V							
10	V							
11	V							
12	V							
13	V							
14	Total		\$ 265,803			\$ 242,616	\$ *	(23,187)

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

Facility Name & ID Number

Swann Special Care Center

0035485

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7/1/09

Ending:

6/30/10

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	10,615			Director Fees	\$ 3,008	18.8	1
2	Stephen Wood	Director	Board Meetings	0.00	51,425			Director Fees	14,572	18.8	2
3	John Gillmor	Director	Board Meetings	0.00	14,636			Director Fees	4,146	18.8	3
4	John Foos	Director	Board Meetings	0.00	10,212			Director Fees	2,894	18.8	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 24,620		13

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

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

Facility Name & ID Number Swann Special Care Center

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7/1/09

Ending: 6/30/10

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization

Hoosier Care, Inc.

Street Address

535 West Second, Suite 105

City / State / Zip Code

Lexington, Kentucky 40508

Phone Number

(859) 255-0075

Fax Number

(859) 281-5150

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Revenue	45,772,634	8	\$ 67,937	\$ 10,106,183	\$ 15,000	1
2	5	Heat & Other Utilities	Revenue	45,772,634	8	6,168	10,106,183	1,362	2
3	6	Maintenance	Revenue	45,772,634	8	5,340	10,106,183	1,179	3
4	10	Nursing / Medical Records	Revenue	45,772,634	8	103,189	10,106,183	22,784	4
5	18	Directors Fees	Revenue	45,772,634	8	111,508	10,106,183	24,620	5
6	19	Professional Services	Revenue	45,772,634	8	415,140	10,106,183	91,663	6
7	20	Dues, Subscriptions & Fees	Revenue	45,772,634	8	1,994	10,106,183	440	7
8	21	Clerical & General Office Exp.	Revenue	45,772,634	8	245,593	10,106,183	54,227	8
9	22	Emp. Benefits & Payroll Tax	Revenue	45,772,634	8	63,169	10,106,183	13,948	9
10	24	Travel & Seminar	Revenue	45,772,634	8	850	10,106,183	188	10
11	30	Depreciation	Revenue	45,772,634	8	950	10,106,183	210	11
12	32	Interest - Working Capital	Revenue	45,772,634	8	66,775	10,106,183	14,743	12
13	34	Rent- Facility	Revenue	45,772,634	8	10,200	10,106,183	2,252	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,098,813	\$	\$ 242,616	25

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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	7	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			
A. Directly Facility Related																			
Long-Term																			
1	Ill. Health Finance Authority	X	Purchase of Facility	Varies	7/8/99	\$ 5,710,000	\$ 5,085,000	6/1/2034	7.1250	\$ 366,035	1								
2	Ill. Health Finance Authority	X	Purchase of Facility	Varies	7/8/99	260,000	180,000	6/2/2019	10.5000	19,688	2								
3											3								
4											4								
5											5								
Working Capital																			
6	Corporate Allocation									14,743	6								
7											7								
8											8								
9	TOTAL Facility Related					\$ 5,970,000	\$ 5,265,000			\$ 400,466	9								
B. Non-Facility Related*																			
10	Debt Allocation	X	Purchase of Facility	Varies	7/8/99		1,186,813	Varies	Varies	87,205	10								
11											11								
12											12								
13											13								
14	TOTAL Non-Facility Related					\$	\$ 1,186,813			\$ 87,205	14								
15	TOTALS (line 9+line14)					\$ 5,970,000	\$ 6,451,813			\$ 487,671	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.)

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

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2009 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 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2005	<u>None</u>	8
	2006	_____	9
	2007	_____	10
	2008	_____	11
	2009	_____	12
Note: The facility became exempt from property taxes starting 1/1/96			
	FOR BHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2009 \$	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.

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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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>SNF/PED</u>	<u>89,603</u>	<u>1989</u>	<u>\$ 538,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	89,603		\$ 538,000	3

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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	87		1989	1975	\$ 2,592,000	\$ 56,275	10-40	\$ 56,275		\$ 1,518,085	4
5	9			1993	319,955	10,665	30	10,665		203,847	5
6	8			1996	N/A		N/A				6
7	8			2000	157,933	5,264	30	5,264		51,328	7
8	11			2004	N/A		N/A				8
	Improvement Type**										
9	Paint & Panels		1989		1,308		3			1,308	9
10	Blinds		1990		384		3			384	10
11	Fire Doors		1990		2,751		10			2,751	11
12	Storm Windows		1991		4,224		10			4,224	12
13	Fire Doors		1991		3,675		10			3,675	13
14	Compressor		1991		1,035		10			1,035	14
15	Carpeting		1991		220		10			220	15
16	Sprinkler & Fire Alarm		1991		695		10			695	16
17	Sprinkler		1992		3,162		10			3,162	17
18	Damper		1992		674		10			674	18
19	Fire Alarm System		1992		1,945		10			1,945	19
20	Water Heater		1992		1,998		7			1,998	20
21	Roofing		1992		3,900		10			3,900	21
22	Voltage Relay		1993		1,875		10			1,875	22
23	Sprinkler System		1993		14,460		10			14,460	23
24	Wall Covering		1993		3,190		10			3,190	24
25	Wall Papering		1993		3,000		10			3,000	25
26	Blinds with Valance		1993		2,395		10			2,395	26
27	Carpet and Rubber Base		1993		2,848		10			2,848	27
28	Replace Siding		1993		575		10			575	28
29	Remodeling in Team Rooms		1993		9,405		10			9,405	29
30	Plexiglas for Doors & Walls		1993		714		10			714	30
31	Resurface Parking Lot		1993		19,115		10			19,115	31
32	Shed		1993		5,990		10			5,990	32
33	Stain New Shed		1993		1,248		10			1,248	33
34	Fire Doors, Closets, Tile		1993		5,225		10			5,225	34
35	Architectural Renovation		1993		855		10			855	35
36	Install Alarm & Nurse Call		1994		688		10			688	36

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

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

See Page 12A, Line 70 for total

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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 Sq Ft Multi-Purpose Activity								53
54	Room & Bathroom Addition + renovation to Dental Office	1996	180,928	9,046	20	9,046		128,910	54
55	Construct Screens, Wheelchairs	1996	1,420		3			1,420	55
56	Construct Shelving, Beds, Screen	1996	2,964		3			2,964	56
57	Install Nurse Call System	1996	1,530		10			1,530	57
58	Tile Flooring & Adhesive	1996	1,227		10			1,227	58
59	Linoleum Flooring	1996	686		10			686	59
60	Install New Drain Pipes	1996	2,190		10			2,190	60
61	Remove Concrete to Replace Drain Pipes	1996	575		10			575	61
62	Install Exit Door Hardware	1997	874		10			874	62
63	Day Training Improvement	1997	4,078		4			4,078	63
64	Install New Disposal	1997	1,069		10			1,069	64
65	Replace Four-Door Glass	1998	520		10			520	65
66	Remove / Replace Underground Fuel Tank	1998	9,223	461	20	461		5,380	66
67	Remodel Project 2410 Springfield	1998	33,764		4			33,764	67
68	Partition Wall Kitchen / Dining Area	1998	595		8			595	68
69	Replace Two Roof-Top HVAC Units-Wings I&II	1998	17,650		10			17,650	69
70	TOTAL (lines 4 thru 69)		\$ 3,466,288	\$ 81,711		\$ 81,711	\$	\$ 2,113,800	70

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

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,466,288	\$ 81,711		\$ 81,711	\$	\$ 2,113,800	1
2	Replace Vent Damper Assembly - Hot Water Heater	1998	740		10			740	2
3	Convert Two Classrooms into Resident Rooms	1998	15,258		10			15,258	3
4	Security Door and Hardware - Converted Rooms	1999	520		10			520	4
5	Remove / Replace Hot Water Heater - Resident Area	1999	3,000		10			3,000	5
6	Replace Combustion Motor/Fan on Heater - West Wing	1999	1,155		10			1,155	6
7	Electrical Service Move Switches	1999	141		8			141	7
8	Installation of Water Heaters	1999	595		10			595	8
9	Resurface Parking Lot	1999	2,350	157	15	157		1,711	9
10	14 Almond FRP Panel Dividers	1999	513		5			513	10
11	Install Alarm System	2000	2,000		5			2,000	11
12	Install Alarm System	2000	2,730		5			2,730	12
13	Replaced Compressor on Freezer	1999	635	10	10	10		635	13
14	Replace Grout, Base, and Tile for Bathroom Floors	1999	594	40	15	40		429	14
15	Replaced Bracket / Filter Head, Brushes, Relay on Generator	1999	2,782	69	10	69		2,782	15
16	Storage Barn	1999	120	5	25	5		52	16
17	Storage Barn	1999	1,045	42	25	42		449	17
18	Replaced Wall Heat Pump Unit	1999	1,525	38	10	38		1,525	18
19	New Mixing / Tempering Valve for Hot Water	2000	629	31	10	31		629	19
20	Replace Timer / Starter on Emergency Generator	2000	2,153	108	10	108		2,153	20
21	Install Interior Retrofit Energy Efficient Lighting	2000	15,090	755	20	755		7,797	21
22	Intstall Clinical Sink	2000	3,030		5			3,030	22
23	Stoneybrook Remodeling PR	2000	138,235		5			138,235	23
24	Install Doors at Kenwood	2000	4,028	269	15	269		2,686	24
25	Replace Gate Valve	2000	6,005	400	15	400		3,937	25
26	Replace Ceiling Tile	2000	674	67	10	67		662	26
27	Materials to Tile Bathroom	2001	784	78	10	78		751	27
28	Install Booster Pump	2001	1,995	133	15	133		1,263	28
29	Install Tile in Bathroom	2001	825	55	15	55		522	29
30	New Floor Drains In Shower	2001	3,180	212	15	212		2,014	30
31	Replace Reversing Valve	2001	599	60	10	60		549	31
32	Replacement Parts for Roof	2001	662	66	10	66		607	32
33	Tile for Bathroom	2001	1,854	185	10	185		1,684	33
34	TOTAL (lines 1 thru 33)		\$ 3,681,734	\$ 84,491		\$ 84,491	\$	\$ 2,314,552	34

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

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,681,734	\$ 84,491		\$ 84,491	\$	\$ 2,314,552	1
2	Stoneybrook Awning	2001	15,560		5			15,560	2
3	Stoneybrook Telephone System	2001	1,668		5			1,668	3
4	Comp. Ed. Room at Stoneybrook	2001	2,431		5			2,431	4
5	Stoneybrook Shelves - Inst	2001	516		5			516	5
6	Remodeling	2001	8,351		5			8,351	6
7	Sprinkler System Renovation	2001	760	51	15	51		456	7
8	Install Shower Drains	2001	10,500	525	20	525		4,725	8
9	Tile to Repalce Tubs	2001	1,278	85	15	85		767	9
10	Rewired and Replaced Compressor / HVAC	2001	1,404	140	10	140		1,252	10
11	Replace Laundry Panel	2001	1,179	79	15	79		688	11
12	Valve-Water Heater	2001	876	88	10	88		767	12
13	Internet Set-up Wiring Cable	2002	6,141	409	15	409		3,446	13
14	Thermostats with Locking Guards	2002	1,371	91	15	91		747	14
15	Classroom Remodel	2002	5,978	598	10	598		4,982	15
16	Replace Fencing Around Dumpster Area	2002	674	67	10	67		550	16
17	Replace Doors	2002	3,000		5			3,000	17
18	Security System	2002	3,165		5			3,165	18
19	Remodeling	2002	8,351		5			8,351	19
20	Electrical Labor-Remodeling	2002	1,425		5			1,425	20
21	Install Two Sinks	2002	3,561		5			3,561	21
22	Revise Sprinkler System	2002	501		5			501	22
23	Re-seal & Re-stripe Parking Lot	2002	2,810	281	10	281		2,248	23
24	Install New Phone System	2002	2,735		5			2,735	24
25	Install New Phone System / Day Training	2002	2,488		5			2,488	25
26	Carpet & Installation	2002	2,954	295	10	295		2,363	26
27	New Mother Board / Alarm System	2002	1,490	149	10	149		1,180	27
28	Install A/C Rooftop Unit	2002	8,237	549	15	549		4,347	28
29	New 2nd Rooftop Compressor	2002	762	51	15	51		398	29
30	Height Adjustment Supine Tub	2002	8,469	847	10	847		6,422	30
31	Relief Valves / Booster Heater	2003	555	56	10	56		416	31
32	Central Heat / Air Rooftop	2003	5,180	345	15	345		2,590	32
33	New Tile and Base Floor	2003	847	85	10	85		635	33
34	TOTAL (lines 1 thru 33)		\$ 3,796,951	\$ 89,283		\$ 89,283	\$	\$ 2,407,283	34

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

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,796,951	\$ 89,283		\$ 89,283	\$	\$ 2,407,283	1
2	New Hydrotherapy Tub	2003	1,900	190	10	190		1,425	2
3	Electric Water Heater	2003	5,600	560	10	560		4,107	3
4	Exhaust Fan	2003	525	53	10	53		372	4
5	Remodeling	2003	8,351		5			8,351	5
6	Install Dry Pendent Sprinkler in Freezer	2003	675	68	10	68		467	6
7	Rooftop Unit Installed / Heat Air Wing 3	2003	10,910	727	15	727		5,031	7
8	60 X 94 Lami Glass	2003	179,834	5,994	30	5,994		37,965	8
9	New Wing	2004	839	120	7	120		799	9
10	Installing Draining System in Courtyard	2004	9,268	1,324	7	1,324		8,495	10
11	5th Annual Payment on Remodeling	2004	8,351		5			8,351	11
12	Drainage System for Courtyard	2004	501	72	7	72		441	12
13	Lift Pump for Drinking Fountain	2004	1,040		5			1,040	13
14	AC Compressor Roof Top Main Building	2004	1,403	23	5	23		1,403	14
15	HVAC Compressor - Office	2004	1,079	18	5	18		1,079	15
16	New Roof	2004	28,855	1,443	20	1,443		8,536	16
17	Exhaust Fan Motor / Thermostat	2005	787	79	10	79		413	17
18	Roofing Project Wing 1,2,&4	2005	66,485	4,432	15	4,432		22,531	18
19	Replace 8 Vinyl Windows	2006	668	67	10	67		289	19
20	Re-Tile Shower Room	2006	10,714	714	15	714		2,976	20
21	Deposit for Duro Last Roof	2006	10,000	667	15	667		2,667	21
22	Compressor for A/C Unit Wing 2	2006	1,506	151	10	151		590	22
23	Duro Last Roof - Payment # 2	2006	4,384	292	15	292		1,169	23
24	100 Amp Sub Panel	2006	2,650	177	15	177		662	24
25	Laundry Room Walls Replaced	2006	2,323	155	15	155		594	25
26	Re-Tile Shower Room # 10	2006	11,642	776	15	776		2,910	26
27	Re-Tile Shower Room # 3	2006	11,642	776	15	776		2,781	27
28	Re-Tile Shower Room # 4	2006	11,642	776	15	776		2,716	28
29	Replace Walls in Dishwasher Area	2006	7,477	498	15	498		1,786	29
30	Dedicated Ground Circuit & Four Outlets	2006	1,513	101	15	101		353	30
31	Replace Kitchen Ceiling Tiles	2006	552	37	15	37		141	31
32	Parking Lot / Dumpster Pad Repaved	2006	8,073	807	10	807		2,960	32
33	Fence / Dumpster Enclosure	2006	2,750	275	10	275		963	33
34	TOTAL (lines 1 thru 33)		\$ 4,210,890	\$ 110,654		\$ 110,654	\$	\$ 2,541,648	34

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

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 4,210,890	\$ 110,654		\$ 110,654	\$	\$ 2,541,648	1
2	Re-Tile Shower Room #s 5,6,7	2007	12,746	850	15	850		2,832	2
3	Curb & Guardrail Around Dumpster Area	2007	2,400	240	15	240		760	3
4	Metal Panels for School Windows	2007	2,158	144	15	144		456	4
5	15 Amp Receptacles	2007	780	52	15	52		165	5
6	Dedicated Ground Circuit for Server	2007	2,400	160	15	160		520	6
7	Electrical Outlets in Family Room	2007	1,222	81	15	81		258	7
8	Re-Tile Team 6 Bathroom	2007	7,561	504	15	504		1,428	8
9	Replace Motors on Roof Exhaust Fans (7)	2007	2,667	267	10	267		778	9
10	Upgrade Lighting System in Education	2007	6,501	433	15	433		1,228	10
11	Remodel Employee Breakroom	2007	2,478	248	10	248		681	11
12	Wire Breakroom & Outlets for Nurses Station	2007	2,574	172	15	172		443	12
13	Window on East Side of Education Building	2008	640	43	15	43		107	13
14	Air Curtain for Laundry Room	2008	1,195	119	10	119		279	14
15	Rooftop Heat Exchange Replaced	2008	2,463	246	10	246		595	15
16	South & Northwest Heat Exchangers	2008	2,421	242	10	242		565	16
17	Replace 2 Doors in Laundry Area	2008	4,187	279	15	279		651	17
18	Plexiglass Window Pane Replaced	2008	527	53	10	53		114	18
19	Remodel Conference Room	2008	2,536	254	10	254		507	19
20	Lift Sunken Sidewalks	2008	1,595	160	10	160		306	20
21	Blower Motor For Rtu #5	2008	1,019	102	10	102		187	21
22	Sprinklers In Conference Room Reconfigured	2008	621	41	15	41		73	22
23	220 Outlet For Stove In Multi-Purpose Room	2008	1,148	77	15	77		128	23
24	Addtnl Outlets (4 Ea.) In Rooms 5,6,8,9,10	2008	7,625	508	15	508		805	24
25	220 Outlet For Stove In Paige II	2008	1,148	57	20	57		91	25
26	Anti-Scald Valve	2009	761	76	10	76		95	26
27	Drainage System For Courtyard	2009	2,250	150	15	150		163	27
28	Compressor for a/c unit	2009	2,830	236	10	236		236	28
29	Induct air purifiers (8) and required electrical	2009	3,638	212	10	212		212	29
30	Dialer for sprinkler system	2010	1,062	53	10	53		53	30
31	Dedicated electric panel for washing machines	2010	1,149	6	15	6		6	31
32	Ceiling tiles	2010	720		10				32
33	Rounding		3	2		2		2	33
34	TOTAL (lines 1 thru 33)		\$ 4,293,915	\$ 116,721		\$ 116,721	\$	\$ 2,556,371	34

**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:

7/1/09

Ending:

6/30/10

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	\$ 335,690	\$ 61,864	\$ 61,864	\$		\$ 170,741	71
72	Current Year Purchases	43,711	3,740	3,740			3,740	72
73	Fully Depreciated Assets	664,080	2,459	2,459			664,080	73
74	Corporate Allocation		210	210				74
75	TOTALS	\$ 1,043,481	\$ 68,273	\$ 68,273	\$		\$ 838,561	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			183,953	20,348	20,348			99,550	79
80	TOTALS			\$ 200,464	\$ 20,348	\$ 20,348	\$		\$ 116,061	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)	\$ 6,075,860	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 205,342	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 205,342	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)	\$ 3,510,993	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.

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				2,252			5
6								6
7	TOTAL				\$ 2,252			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: \$ 9,765 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

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 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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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				
3	Classroom Wages (a)		5,600		5,600
4	Clinical Wages (b)		11,200		11,200
5	In-House Trainer Wages (c)		2,224		2,224
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests		2,040		2,040
9	TOTALS	\$	\$ 21,064	\$	\$ 21,064
10	SUM OF line 9, col. 1 and 2 (e)	\$	21,064		

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	16
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	16

- (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	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service			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.

Facility Name & ID Number Swann Special Care Center

0035485

Report Period Beginning: 7/1/09

Ending: 6/30/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/10 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 2,582	\$	1
2	Cash-Patient Deposits	98,440		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>114,367</u>)	1,696,079		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	41,209		6
7	Other Prepaid Expenses	18,768		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,857,078	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	538,000		13
14	Buildings, at Historical Cost	4,293,915		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,243,945		16
17	Accumulated Depreciation (book methods)	(3,510,993)		17
18	Deferred Charges	321,697		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):	569,293		22
23	Other(specify): <u>Goodwill</u>	531,191		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,987,048	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,844,126	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 179,238	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	98,441		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	297,073		30
31	Accrued Taxes Payable (excluding real estate taxes)	8,385		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	38,935		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Due to / from corporate</u>	382,339		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,004,411	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	6,451,813		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)	\$ 6,451,813	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,456,224	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,612,098)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,844,126	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,388,846)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,388,846)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	776,748	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)	\$ 776,748	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)	\$ (1,612,098)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Swann Special Care Center# 0035485Report Period Beginning: 7/1/09Ending: 6/30/10

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	\$ 7,527,483	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,527,483	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education	988,441	9
10	Other Government Grants	69,103	10
11	CNA Training Reimbursements	11,345	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	26,151	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,095,040	23
D. Non-Operating Revenue			
24	Contributions	16,569	24
25	Interest and Other Investment Income***	(1,126)	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 15,443	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>DMH Day Training</u>	1,496,400	28
28a	<u>Miscellaneous Income</u>	20	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,496,420	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,134,386	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,081,909	31
32	Health Care	3,507,318	32
33	General Administration	2,158,919	33
B. Capital Expense			
34	Ownership	729,158	34
C. Ancillary Expense			
35	Special Cost Centers	1,464,808	35
36	Provider Participation Fee	415,529	36
D. Other Expenses (specify):			
37	<u>Rounding</u>	(3)	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,357,638	40
41	Income before Income Taxes (line 30 minus line 40)**	776,748	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 776,748	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.

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

Facility Name & ID Number Swann Special Care Center

0035485

Report Period Beginning:

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6/30/10

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	1,707	1,906	\$ 59,553	\$ 31.25	1
2	Assistant Director of Nursing	103	110	3,299	29.99	2
3	Registered Nurses	32,444	35,073	950,696	27.11	3
4	Licensed Practical Nurses	12,447	13,679	271,177	19.82	4
5	CNAs & Orderlies	106,061	114,000	1,470,707	12.90	5
6	CNA Trainees					6
7	Licensed Therapist	4,227	4,442	47,314	10.65	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,806	2,062	36,728	17.81	9
10	Activity Assistants	17,263	18,571	167,628	9.03	10
11	Social Service Workers	59	66	2,961	44.86	11
12	Dietician	103	120	2,851	23.76	12
13	Food Service Supervisor	1,846	2,164	46,330	21.41	13
14	Head Cook	13,484	14,949	192,243	12.86	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,953	4,167	58,251	13.98	17
18	Housekeepers					18
19	Laundry	1,913	2,114	32,282	15.27	19
20	Administrator	1,811	2,029	64,742	31.91	20
21	Assistant Administrator					21
22	Other Administrative	4,057	4,384	58,175	13.27	22
23	Office Manager					23
24	Clerical	5,577	6,212	143,922	23.17	24
25	Vocational Instruction					25
26	Academic Instruction	29,499	31,978	504,616	15.78	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 C: Ward Clerk	1,669	1,755	18,084	10.30	32
33	Other(specify) Day Training	50,814	54,264	635,115	11.70	33
34	TOTAL (lines 1 - 33)	290,843	314,045	\$ 4,766,674 *	\$ 15.18	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	373	\$ 17,108	1.3	35
36	Medical Director	N/A	36,800	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	N/A	3,306	10.3	39
40	Physical Therapy Consultant	N/A	4,575	10A.3	40
41	Occupational Therapy Consultant	968	60,503	10A.3	41
42	Respiratory Therapy Consultant	N/A	2,599	10A.3	42
43	Speech Therapy Consultant	1,011	72,600	10A.3	43
44	Activity Consultant				44
45	Social Service Consultant	36	2,494	12.3	45
46	Other(specify) Dental Fees	N/A	5,748	10.3	46
47	Resident Transport	N/A	13,512	14.3	47
48	See Attached	290	369,668		48
49	TOTAL (lines 35 - 48)	2,678	\$ 588,913		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses			50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)		\$	53

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	
Kathleen Baker	Administrator	0	\$ 64,742	Workers' Compensation Insurance	\$ 100,724	IDPH License Fee	\$	
				Unemployment Compensation Insurance	(2,134)	Advertising: Employee Recruitment		
				FICA Taxes	351,117	Health Care Worker Background Check		
				Employee Health Insurance	267,025	(Indicate # of checks performed <u>37</u>)	581	
				Employee Meals		Illinois Health Care Assoc.	6,790	
				Illinois Municipal Retirement Fund (IMRF)*		NAEIR	149	
				Employee Benefits - Other	20,352	Chamber of Commerce	235	
				Employee Benefits - Retirement Plan	2,930	National Notary Association	112	
				Corporate Allocation	13,948	Corporate Allocation	440	
						Other Fees	10,113	
						Less: Public Relations Expense	(6,426)	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 64,742	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 753,962		\$ 11,994		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description	Amount			Description	Line #	Amount	Description	Amount
Corporate Expense	\$ 265,803					\$	Out-of-State Travel	\$ 0
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 265,803				In-State Travel	7,632
							Non-Allowable	(391)
							Seminar Expense	7,792
							Nurse Aide Training Reclass	(2,040)
							Corporate Allocation	188
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 659,862	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	
							\$ 13,181	

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Swann Special Care Center

0035485

Report Period Beginning:

7/1/09

Ending: 6/30/10

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? 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. \$ 415,529
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. \$ 69,103
- (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? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 1,395
- 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. \$ 46,617
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Reznick Group
- (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.