Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$		-	$	1
2										-		2
3										-		3
4										-		4
5										-		5
	Working Capital											
6	Promissory Note		x	Operations		7/2003	41,891		7/2008	0.0400	475	6
7										-		7
8										-		8
9	TOTAL Facility Related						$ 41,891	$			$ 475	9
	B. Non-Facility Related*											
10										-		10
11										-		11
12										-		12
13										-		13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 41,891	$			$ 475	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.)

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	Important, please see the next worksheet, "RE Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 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		8
2006		9
2007		10
2008		11
2009		12

	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2009 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2009 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2009.

Please complete the Real Estate Tax Statement below and include it in the 2010 cost report along with a copy of your 2009 real estate tax bill.

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

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Apostolic Christian Skylines COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0006353

CONTACT PERSON REGARDING THIS REPORT Matt Feucht

TELEPHONE (309) 691-8091 FAX #: (309) 683-2505

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 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.

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 57,400 B. General Construction Type: Exterior Brick Frame Steel & Masonry Number of Stories Two

C. Does the Operating Entity? [x] (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? [x] (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).

Apartments & Assisted Living: 18,850 sq. ft., 3 Independent Living Units & 14 Assisted Living Units.
Duplexes: 1,150 sq. ft. per unit, 16 Units.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] 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	Nursing Home	200,000	1964	$ 743	1
2					2
3	TOTALS	200,000		$ 743	3

Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available.

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	29		1966	1965	$ 348,310	$ 8,708	40	$ 8,708	$	$ 316,964	4
5	21		1971	1970	396,963	9,924	40	9,924		321,540	5
6	16		1985	1985	750,000	18,750	40	18,750		397,500	6
7	3		1989	1988	205,070	5,127	40	5,127		92,283	7
8	17		1995	1995	870,388	21,760	40	21,760		308,989	8
	Improvement Type**										
9	17 bed room addition			1996	793,538	19,838	40	19,838		245,995	9
10	Shelter care remodel			1974	6,594	165	40	165		5,700	10
11	Fire prevention system			1977	23,804	952	25	952		20,319	11
12	Dining room addition			1978	38,922	973	40	973		32,469	12
13	Fire prevention system			1979	35,330	1,413	25	1,413		32,350	13
14	Windows replacement			1981	23,820	953	25	953		21,371	14
15	Kitchen remodel			1982	21,631	541	40	541		17,242	15
16	Energy conservation			1983	8,413		15	254	254	8,413	16
17	Shelter care remodel			1984	7,742	194	40	194		6,002	17
18	Cabinets			1986	1,618		15	107	107	1,618	18
19	Air conditioning units			1987	6,427		10			6,427	19
20	Physical therapy remodel			1989	11,503	288	40	288		8,118	20
21	Office Addition			1991	50,297	1,257	40	1,257		33,697	21
22	New roof			1993	14,210		10	309	309	14,210	22
23	Room remodel			1994	5,154	206	25	206		3,579	23
24	Front entrance, front office, ceiling back hall			1996	62,294	3,115	20	3,115		43,607	24
25	Guttering System			1996	89,096	3,564	25	3,564		49,895	25
26	Fencing, soffit/facia, new door			1997	28,036	1,121	25	1,121		14,904	26
27	Flooring, lighting, wall covering			1998	88,061		5			88,061	27
28	Door & fire alarms			2000	4,978	332	15	332		2,595	28
29	Flooring, lighting, wall covering			2000	97,127		5			97,127	29
30	Flooring, lighting, wall covering			2001	28,745		5			28,745	30
31	Lobby windows			2001	3,577	143	25	143		1,574	31
32	Blacktopping			2001	13,967	1,746	8	1,746		11,785	32
33	Balcony repair			2001	6,605	544	20	330	(214)	4,372	33
34	Insulation installation			2001	9,970	665	15	665		4,924	34
35	Lawn sprinkler system			2001		643	15		(643)		35
36	Air Conditioning Unit			2001	2,178	218	10	218		1,480	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

Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available.

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Locks	2002	$ 691	$ 35	20	$ 35	$	$ 254	37
38	Flooring, tub, wall covering	2002	14,570	728	20	729	1	6,455	38
39	Flooring, wall covering	2002	9,786		5			9,786	39
40	Balcony repair	2002	7,403	370	20	370		3,278	40
41	Carpeting in dining room	2002	5,446		5			5,446	41
42	Water heater	2002	4,197	420	10	420		2,747	42
43	Lawn sprinkler system	2002		593	15		(593)		43
44	Sewer system upgrade	2002		320	20		(320)		44
45	Air Conditioning unit	2003	1,700	85	20	85		641	45
46	Sewer system upgrade	2003		320	20		(320)		46
47	Countertops in kitchen	2003	6,594	440	15	440		2,793	47
48	Carpeting	2004	5,878		5	782	782	5,878	48
49	Wiremesh	2004	1,825	122	15	122		732	49
50	Sewer system upgrade	2004		450	20		(450)		50
51	Electrical panel upgrade	2004	2,068	138	15	138		782	51
52	Water heater	2004	7,646	765	10	765		4,207	52
53	Rewiring	2004	1,327	66	20	66		341	53
54	Roofing	2005	4,858	486	10	486		2,713	54
55	Tub room remodel	2005	3,855	154	25	154		834	55
56	Carpeting	2005	2,128	284	5	282	(2)	2,128	56
57	Alarm system	2005	2,357	157	15	157		811	57
58	External water carryoff system	2005	512	21	25	20	(1)	100	58
59	Nurses Station Connector	2006	364,158	9,679	40	9,104	(575)	40,980	59
60	Door latches	2006	7,110	178	40	178		862	60
61	Automatic Doors	2006	2,886	192	15	192		865	61
62	Walk-in Cooler upgrades	2006	3,135	314	10	314		1,521	62
63	Fire safety improvements	2007	19,182	480	40	480		1,457	63
64	Garage	2007	5,944	149	40	149		456	64
65	Locks	2007	691	69	10	69		276	65
66	Office expansion - social services	2007	2,346	59	40	59		229	66
67	Elevator jack replacement	2007	35,560	1,778	20	1,778		6,873	67
68	Fire hydrant - sprinkler heads	2007	5,719	286	20	286		939	68
69	Wood door	2007	942	63	15	63		203	69
70	TOTAL (lines 4 thru 69)		$ 4,584,882	$ 122,341		$ 120,676	$ (1,665)	$ 2,348,442	70

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

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,584,882	$ 122,341		$ 120,676	$ (1,665)	$ 2,348,442	1
2	Air conditioner compressor	2007	8,418	842	10	842		2,717	2
3	Sprinklers	2007	1,230	62	20	62		199	3
4	Maglock outswing door	2007	1,173	117	10	117		462	4
5	81 gal water heater - kitchen	2007	5,797	580	10	580		2,153	5
6	Heat exchangers	2007	8,455	423	20	423		1,539	6
7	Disposer 3 hp	2007	3,472	347	10	347		1,178	7
8	Door monitoring unit	2007	1,103	110	10	110		341	8
9	Sprinkler-kitchen; flooring-306; fire safety improvs	2008	60,117	1,679	48	1,252	(427)	2,847	9
10	Walkway and snow melt	2008	5,357	357	15	357		812	10
11	Septic field St. Luke Ct	2008	10,726	268	50	215	(53)	539	11
12	Iron guard hand railings	2008	6,781	452	15	452		947	12
13	Commercial disposal	2008	1,487	149	10	149		380	13
14	Rm flooring, wall	2008	6,604	165	40	165		330	14
15	Internet wiring	2009	4,849	242	20	242		383	15
16	Heat valves in room radiators, boiler tank, valves, zone control	2009	11,703	585	20	585		731	16
17	Water heater	2009	13,950	930	20	698	(232)	776	17
18	Air conditioning units	2009	2,673	267	25	107	(160)	208	18
19	Salem cabinetry refacing	2009	7,230	362	20	362		543	19
20	Dining room walls	2009	5,391	142	40	135	(7)	227	20
21	Hallway ceiling, public bath toilet, cabinet, hardware	2009	6,323	352	20	316	(36)	617	21
22	Rm 304 toilet, shower, hardware	2009	3,910	156	25	156		286	22
23	Lwr southbathrm architectural work	2009	6,935	277	25	277		396	23
24	Senior TV hook-up	2009	250	13	20	13		14	24
25	Salem architectural	2009	3,392	136	25	136		204	25
26	Flooring, basebd Salem rm 141-149	2009	25,793	1,032	25	1,032		1,290	26
27	Flooring, basebd Salem dining rm	2009	9,028	361	25	361		451	27
28	Flooring Salem lounge	2009	14,443	578	25	578		674	28
29	Salem wall, kitchen wall & backsplsh, shower floor	2009	18,994	760	25	760		762	29
30	Social room tv cabinetry	2009	990	50	20	50		50	30
31	Drywall, carpet Canaan room	2009	2,769	111	25	111		111	31
32	Maglock outswing door, sensor push bars	2009	2,999	189	20	150	(39)	299	32
33	Fire safety improvements & sprinkler upgrade	2009	21,562	587	40	539	(48)	744	33
34	TOTAL (lines 1 thru 33)		$ 4,868,786	$ 135,022		$ 132,355	$ (2,667)	$ 2,371,652	34

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

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 4,868,786	$ 135,022		$ 132,355	$ (2,667)	$ 2,371,652	1
2	Roofing, flooring rm 226	2009	8,432	641	15	562	(79)	669	2
3	A/C dine rm; kitchen; rm 120; hallway; nursing admin ofc	2010	10,941	288	10	222	(66)	222	3
4	Elevator repair	2010	11,900	893	10	945	52	945	4
5	Salem flooring, baseboards	2010	14,608	292	25	295	3	295	5
6	Lwr southbathrm toilet, flooring, wall	2010	4,372	44	25	44		44	6
7	Nurses Station	2010	2,278	38	10	37	(1)	37	7
8	Flooring Canaan room	2010	870	87	5	88	1	88	8
9	Dining room flooring	2010	1,190	59	15	60	1	60	9
10	New burner boiler 1	2010	12,225	82	25	99	17	99	10
11	Commercial water heater	2010	4,900	54	15	46	(8)	46	11
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32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,940,502	$ 137,500		$ 134,753	$ (2,747)	$ 2,374,157	34

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

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 4,940,502	$ 137,500		$ 134,753	$ (2,747)	$ 2,374,157	1
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32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,940,502	$ 137,500		$ 134,753	$ (2,747)	$ 2,374,157	34

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

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 4,940,502	$ 137,500		$ 134,753	$ (2,747)	$ 2,374,157	1
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33									33
34	TOTAL (lines 1 thru 33)		$ 4,940,502	$ 137,500		$ 134,753	$ (2,747)	$ 2,374,157	34

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

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 4,940,502	$ 137,500		$ 134,753	$ (2,747)	$ 2,374,157	1
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32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,940,502	$ 137,500		$ 134,753	$ (2,747)	$ 2,374,157	34

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

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 4,940,502	$ 137,500		$ 134,753	$ (2,747)	$ 2,374,157	1
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32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,940,502	$ 137,500		$ 134,753	$ (2,747)	$ 2,374,157	34

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

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	$ 837,211	$ 59,287	$ 59,287	$	Various	$ 498,364	71
72	Current Year Purchases	102,506	7,640	7,640		Various	7,640	72
73	Fully Depreciated Assets	143,433					143,433	73
74								74
75	TOTALS	$ 1,083,150	$ 66,927	$ 66,927	$		$ 649,437	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 Transport	99 Ford Bus	2005	$ 58,988	$	$	$	4	$ 58,988	76
77	Maintenance	02 John Deere	2005	6,475				3	6,475	77
78										78
79	Patient Transport	06 Ford Van	2006	36,187	7,237	7,237		5	29,563	79
80	TOTALS			$ 101,650	$ 7,237	$ 7,237	$		$ 95,026	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)	$ 6,126,045	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 211,664	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 208,917	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (2,747)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,118,620	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	Building	Various	$ 1,715,057	$ 48,597	$ 942,213	86
87	Equipment	Various	185,596	15,518	89,456	87
88	Vehicle	Various	22,254	2,872	39,489	88
89	Land	Various	112,446			89
90						90
91	TOTALS		$ 2,035,353	$ 66,987	$ 1,071,158	91

G. Construction-in-Progress

	Description	Cost	
92	Construction In Progress	$ 200,960	92
93			93
94			94
95		$ 200,960	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.

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

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 [x] 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 [x] NO Terms: *

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	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [x] 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

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

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

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [x] YES [ ] NO

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

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [x]
- COMMUNITY COLLEGE [ ]
- HOURS PER CNA 80

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [x]
- HOURS PER CNA 40

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 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		1,220		1,220
8	CNA Competency Tests				
9	TOTALS	$	$ 1,220	$	$ 1,220
10	SUM OF line 9, col. 1 and 2 (e)	$ 1,220			

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

(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.

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a.3	hrs	$	162	$ 12,613	$	162	$ 12,613	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		588	37,636		588	37,636	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs		187	15,335		187	15,335	4
5	Physician Care	39.3	visits							5
6	Dental Care	39.3	visits		24	1,800		24	1,800	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39.2	# of prescrpts				34,006		34,006	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Exceptional Care	39.2								12
13	Other (specify): Medical Supplies	39.2					1,379		1,379	13
14	TOTAL			$	961	$ 67,384	$ 35,385	961	$ 102,769	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.

STATE OF ILLINOIS

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2010 (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	$ 187,522	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	629,264		3
4	Supply Inventory (priced at FIFO)	8,197		4
5	Short-Term Investments	181,725		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	110,265		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	$ 1,116,973	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	113,189		13
14	Buildings, at Historical Cost	6,638,875		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,338,666		16
17	Accumulated Depreciation (book methods)	(4,359,876)		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): Construction In Progress	200,960		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	$ 3,931,814	$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	$ 5,048,787	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 403,335	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	17,396		29
30	Accrued Salaries Payable	51,765		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)	$ 472,496	$	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	Contingency Payable			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	$	$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	$ 472,496	$	46
47	TOTAL EQUITY(page 18, line 24)	$ 4,576,291	$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	$ 5,048,787	$	48

*(See instructions.)

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	$ 4,555,255	1
2	Restatements (describe):		2
3			3
4	Prior period adjustments	57,202	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	$ 4,612,457	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(36,166)	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)	$ (36,166)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	$ 4,576,291	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,894,666	1
2	Discounts and Allowances for all Levels	(394,345)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	$ 4,500,321	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	210,226	6
7	Oxygen	20,999	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	$ 231,225	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	10	12
13	Barber and Beauty Care	28,921	13
14	Non-Patient Meals	27,175	14
15	Telephone, Television and Radio	11,764	15
16	Rental of Facility Space		16
17	Sale of Drugs	27,937	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,835	19
20	Radiology and X-Ray	3,440	20
21	Other Medical Services	230,972	21
22	Laundry	644	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	$ 333,698	23
	D. Non-Operating Revenue		
24	Contributions	299,899	24
25	Interest and Other Investment Income***	689	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	$ 300,588	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)	4,480	27
28	Non-Care Facility	18,863	28
28a	Miscellaneous Income	23,811	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	$ 47,154	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	$ 5,412,986	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,102,937	31
32	Health Care	2,607,974	32
33	General Administration	1,356,591	33
	B. Capital Expense		
34	Ownership	279,126	34
	C. Ancillary Expense		
35	Special Cost Centers	71,316	35
36	Provider Participation Fee	31,208	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	$ 5,449,152	40
41	Income before Income Taxes (line 30 minus line 40)**	(36,166)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	$ (36,166)	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 Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,974	2,080	$ 62,721	$ 30.15	1
2	Assistant Director of Nursing	1,948	2,080	51,346	24.69	2
3	Registered Nurses	11,170	13,469	332,342	24.68	3
4	Licensed Practical Nurses	18,621	21,076	433,695	20.58	4
5	CNAs & Orderlies	70,140	77,012	941,841	12.23	5
6	CNA Trainees	-	-	-		6
7	Licensed Therapist	-	-	-		7
8	Rehab/Therapy Aides	4,817	5,650	90,204	15.97	8
9	Activity Director	1,899	1,955	34,951	17.88	9
10	Activity Assistants	11,095	12,334	126,239	10.23	10
11	Social Service Workers	1,725	1,816	36,619	20.17	11
12	Dietician	-	-	-		12
13	Food Service Supervisor	-	-	-		13
14	Head Cook	6,260	7,220	144,232	19.98	14
15	Cook Helpers/Assistants	12,744	14,639	145,978	9.97	15
16	Dishwashers	-	-	-		16
17	Maintenance Workers	5,812	7,033	131,640	18.72	17
18	Housekeepers	9,361	10,587	103,259	9.75	18
19	Laundry	4,649	5,340	46,244	8.66	19
20	Administrator	2,039	2,080	83,252	40.03	20
21	Assistant Administrator	2,040	2,080	58,345	28.05	21
22	Other Administrative	-	-	-		22
23	Office Manager	-	-	-		23
24	Clerical	8,754	9,365	115,825	12.37	24
25	Vocational Instruction	-	-	-		25
26	Academic Instruction	-	-	-		26
27	Medical Director	-	-	-		27
28	Qualified MR Prof. (QMRP)	-	-	-		28
29	Resident Services Coordinator	-	-	-		29
30	Habilitation Aides (DD Homes)	-	-	-		30
31	Medical Records	1,935	2,236	29,378	13.14	31
32	Other Health Care: HomeCare	8,863	9,110	135,918	14.92	32
33	Other(specify)	-	-	-		33
34	TOTAL (lines 1 - 33)	185,845	207,161	$ 3,104,028 *	$ 14.98	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	264	$ 10,562	1.3	35
36	Medical Director	6	425	9.3	36
37	Medical Records Consultant	32	2,095	10.3	37
38	Nurse Consultant	-	-	10.3	38
39	Pharmacist Consultant	43	3,438	10.3	39
40	Physical Therapy Consultant	24	1,504	10a.3	40
41	Occupational Therapy Consultant	28	1,786	10a.3	41
42	Respiratory Therapy Consultant	-	-		42
43	Speech Therapy Consultant	22	1,382	10a.3	43
44	Activity Consultant	21	825	11.3	44
45	Social Service Consultant	-	-	12.3	45
46	Other(specify)	-			46
47					47
48					48
49	TOTAL (lines 35 - 48)	440	$ 22,017		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	341	$ 7,280	10.3	50
51	Licensed Practical Nurses	1,142	38,240	10.3	51
52	Certified Nurse Assistants/Aides	396	7,616	10.3	52
53	TOTAL (lines 50 - 52)	1,879	$ 53,136		53

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Matt Feucht	Administrator		$ 83,252
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 83,252

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Payroll Processing	Accounting	$ 16,892
Husch-Blackwell-Sanders LLP	Legal	1,962
Robert Rein CPA	Consulting	5,655
Reclassifications		1,013
FR&R Consulting In.	Consulting	438
Gorenz and Associates	Accounting	2,505
Adjustments		10,000
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 38,465

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 73,912
Unemployment Compensation Insurance	3,078
FICA Taxes	236,033
Employee Health Insurance	315,387
Employee Meals	35,325
Illinois Municipal Retirement Fund (IMRF)*	
401k Plan & Administration	68,858
Employee Physical	14,682
Employee Incentives	40,982
Uniform Allowance	(60)
Rounding	
TOTAL (agree to Schedule V, line 22, col.8)	$ 788,197

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	19,885
Health Care Worker Background Check	2,421
(Indicate # of checks performed 121)	
Patient Background Checks 24	240
Life Services Network Dues	4,658
Publications	697
Licenses	3,668
Other Membership Dues	254
Less: Public Relations Expense	( )
Non-allowable advertising	(3,037)
Yellow page advertising	(160)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 28,626

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ (1,378)
In-State Travel	1,595
Seminar Expense	3,145
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,362

**See instructions.

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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. Life Services Network Dues 4,658

(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? yes

(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? 86

(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? 7

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ $ 33,086 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.

(9) Are you presently operating under a sublease agreement? YES no NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO no 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. $ 31,208
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. $ 35,325 Has any meal income been offset against related costs? yes Indicate the amount. $ 27,176

(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? 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? no
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? no
Firm Name:

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.