FOR BHF USE

LL1

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

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0029199

Facility Name: Burgess Square Healthcare Ctr

Address: 5801 South Cass Avenue (Number) Westmont (City) 60559 (Zip Code)

County: Dupage

Telephone Number: (630) 971-2645 **Fax #** (630) 971-1961

HFS ID Number:

Date of Initial License for Current Owners: 01/23/1985

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236-1111
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/10 to 12/31/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) Andrew B. Cutler
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Burgess Square Healthcare Ctr # 0029199 Report Period Beginning: 01/01/10 Ending: 12/31/10

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	203	Skilled (SNF)	203	74,095	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	203	TOTALS	203	74,095	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,647	1,644	15,812	19,103	8
9	SNF/PED					9
10	ICF	28,277	15,137	1,139	44,553	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,924	16,781	16,951	63,656	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.91%

D. How many bed-hold days during this year were paid by the Department?
None (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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/01/1984

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/01/1984 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 203 and days of care provided 15,123

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Burgess Square Healthcare Ctr # 0029199 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	412,155	91,047		503,202		503,202		503,202			1
2	Food Purchase		374,673		374,673		374,673	(988)	373,685			2
3	Housekeeping	387,482	65,420		452,902		452,902		452,902			3
4	Laundry	82,466	33,144		115,610		115,610		115,610			4
5	Heat and Other Utilities			260,569	260,569		260,569		260,569			5
6	Maintenance	109,681	81,762	210,887	402,330		402,330	(17,015)	385,315			6
7	Other (specify):*											7
8	TOTAL General Services	991,784	646,046	471,456	2,109,286		2,109,286	(18,002)	2,091,284			8
	B. Health Care and Programs											
9	Medical Director			59,250	59,250		59,250		59,250			9
10	Nursing and Medical Records	4,767,750	636,821	104,014	5,508,585		5,508,585		5,508,585			10
10a	Therapy	367,288	54,710		421,998		421,998		421,998			10a
11	Activities	192,121	15,409	2,031	209,561		209,561		209,561			11
12	Social Services	199,441		1,357	200,798		200,798		200,798			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	5,526,600	706,940	166,652	6,400,192		6,400,192		6,400,192			16
	C. General Administration											
17	Administrative	238,641		1,055,500	1,294,141		1,294,141	(136,734)	1,157,407			17
18	Directors Fees											18
19	Professional Services			341,645	341,645		341,645	(159,343)	182,302			19
20	Dues, Fees, Subscriptions & Promotions			54,792	54,792		54,792	(26,125)	28,667			20
21	Clerical & General Office Expenses	418,060	94,367	676,749	1,189,176		1,189,176	(588,189)	600,987			21
22	Employee Benefits & Payroll Taxes			1,637,642	1,637,642		1,637,642	(3,582)	1,634,060			22
23	Inservice Training & Education											23
24	Travel and Seminar			17,029	17,029		17,029	(175)	16,854			24
25	Other Admin. Staff Transportation			8,690	8,690		8,690	(3,233)	5,457			25
26	Insurance-Prop.Liab.Malpractice			109,924	109,924		109,924		109,924			26
27	Other (specify):*							40,359	40,359			27
28	TOTAL General Administration	656,701	94,367	3,901,971	4,653,039		4,653,039	(877,022)	3,776,017			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,175,085	1,447,353	4,540,079	13,162,517		13,162,517	(895,025)	12,267,492			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Burgess Square Healthcare Ctr #0029199 Report Period Beginning: 01/01/10 Ending: 12/31/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			397,787	397,787		397,787	(183,485)	214,302			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			44,424	44,424		44,424	367,398	411,822			32
33	Real Estate Taxes			125,755	125,755		125,755		125,755			33
34	Rent-Facility & Grounds			825,908	825,908		825,908	(521,864)	304,044			34
35	Rent-Equipment & Vehicles			10,373	10,373		10,373		10,373			35
36	Other (specify):*											36
37	TOTAL Ownership			1,404,247	1,404,247		1,404,247	(337,951)	1,066,296			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	1,048,384	761,811	99,670	1,909,865		1,909,865		1,909,865			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			114,161	114,161		114,161	(3,019)	111,143			42
43	Other (specify):*	87,342			87,342		87,342	(87,342)	0			43
44	TOTAL Special Cost Centers	1,135,726	761,811	213,831	2,111,368		2,111,368	(90,360)	2,021,008			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	8,310,811	2,209,164	6,158,157	16,678,132		16,678,132	(1,323,336)	15,354,796			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Burgess Square Healthcare Ctr # 0029199 Report Period Beginning: 01/01/10 Ending: 12/31/10

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 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	(252,658)	30		9
10	Interest and Other Investment Income	(3,520)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(988)	02		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	(3,952)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(511,301)	21		24
25	Fund Raising, Advertising and Promotional	(11,532)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(282)	20		28
29	Other-Attach Schedule	(363,057)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,147,290)		$	30

BHF USE ONLY									
48		49		50		51		52	

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 Amount	2 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)	(176,046)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (176,046)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,323,336)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS **Page 5A**

Burgess Square Healthcare Ctr

ID# **0029199**

Report Period Beginning: **01/01/10**

Ending: **12/31/10**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Salaries	$ (87,342)	43	1
2	Public Relations	(68,673)	21	2
3	Theft & Damage Loss	(1,735)	21	3
4	PY Non-Allowable Legal	(20,007)	19	4
5	Non-Allowable Legal	(139,337)	19	5
6	Non-Allowable Travel	(3,233)	25	6
7	Bank Fees	(30)	21	7
8	Non-Allowable Seminar Expense	(175)	24	8
9	Cable TV	(11,440)	06	9
10	State Replacement Tax	(6,000)	21	10
11	Additional R&M	20,960	06	11
12	Capitalized R&M	(26,535)	06	12
13	Prior Period Adj. - Home Bad Tax	(3,019)	42	13
14	Life Insurance Officer	(3,582)	22	14
15	Trust Fees	(450)	21	15
16	Lobbying Dues - IHCA	(10,359)	20	16
17	Bldg. Co. - Bank Charges	(67)	21	17
18	Bldg. Co. - Franchise Tax	(250)	21	18
19	Bldg. Co. - Settlement Charges	(1,785)	21	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**	(363,057)		49

Burgess Square Healthcare Ctr

ID# 0029199

Report Period Beginning: 01/01/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98				49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Burgess Square Healthcare Ctr # 0029199 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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													1
2	Food Purchase	(988)											(988)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities													5
6	Maintenance	(17,015)											(17,015)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(18,002)											(18,002)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**													16
	C. General Administration													
17	Administrative			(136,734)									(136,734)	17
18	Directors Fees													18
19	Professional Services	(159,343)											(159,343)	19
20	Fees, Subscriptions & Promotions	(26,125)											(26,125)	20
21	Clerical & General Office Expenses	(590,291)	2,102										(588,189)	21
22	Employee Benefits & Payroll Taxes	(3,582)											(3,582)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(175)											(175)	24
25	Other Admin. Staff Transportation	(3,233)											(3,233)	25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*			40,359									40,359	27
28	**TOTAL General Administration**	(782,749)	2,102	(96,375)									(877,022)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(800,752)	2,102	(96,375)									(895,025)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Burgess Square Healthcare Ctr # 0029199 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(252,658)	69,173										(183,485)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(3,520)	370,918										367,398	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(521,864)										(521,864)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	**TOTAL Ownership**	(256,178)	(81,773)										(337,951)	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	(3,019)											(3,019)	42
43	Other (specify):*	(87,342)											(87,342)	43
44	**TOTAL Special Cost Centers**	(90,360)											(90,360)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,147,290)	(79,671)	(96,375)									(1,323,336)	45

Facility Name & ID Number Burgess Square Healthcare Ctr # 0029199 Report Period Beginning: 01/01/10 Ending: 12/31/10

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
Monty Miller	100%	N/A		United Care	Ovando, Montana	Mgmt. Co.

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 521,864	The Ream Group, LLC	100.00%	$	$ (521,864)	1
2	V	21	Bank Charges		The Ream Group, LLC	100.00%	67	67	2
3	V	30	Depreciation		The Ream Group, LLC	100.00%	69,173	69,173	3
4	V	21	Franchise Tax		The Ream Group, LLC	100.00%	250	250	4
5	V	32	Interest Expense - MRTG		The Ream Group, LLC	100.00%	363,940	363,940	5
6	V	32	Interest Expense - LOC		The Ream Group, LLC	100.00%	6,978	6,978	6
7	V	21	Settlement Charges		The Ream Group, LLC	100.00%	1,785	1,785	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 521,864			$ 442,193	$ * (79,671)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Burgess Square Healthcare Ctr # 0029199 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Management Fees	$ 1,055,500	United Care	100.00%	$	$ (1,055,500)	15
16	V								16
17	V	17	Wages Other		United Care	100.00%	718,766	718,766	17
18	V	17	Administrative		United Care	100.00%	200,000	200,000	18
19	V	27	Employee Benefits		United Care	100.00%	40,359	40,359	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,055,500			$ 959,125	$ * (96,375)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Burgess Square Healthcare Ctr # 0029199 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Burgess Square Healthcare Ctr # 0029199 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Burgess Square Healthcare Ctr # 0029199 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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.

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15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Burgess Square Healthcare Ctr # 0029199 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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.

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15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Burgess Square Healthcare Ctr # 0029199 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Burgess Square Healthcare Ctr # 0029199 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Burgess Square Healthcare Ctr # 0029199 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Burgess Square Healthcare Ctr # 0029199 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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.

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15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Burgess Square Healthcare Ctr # 0029199 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Monty Miller	Vice President	Admin	100.00%	N/A	20.00	50.00%	Salary	$ 200,000	17-7	1
2											2
3											3
4											4
5	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only amounts anticipated to be considered allowable										5
6	by the Il. Dept of HFS.										6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 200,000		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 Burgess Square Healthcare Ctr # 0029199 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X]

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Burgess Square Healthcare Ctr # 0029199 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
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21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

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Facility Name & ID Number Burgess Square Healthcare Ctr # 0029199 Report Period Beginning: 01/01/10 Ending: 12/31/10

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21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

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22										22
23										23
24										24
25	TOTALS					$	$		$	25

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22										22
23										23
24										24
25	TOTALS					$	$		$	25

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23										23
24										24
25	TOTALS					$	$		$	25

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19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

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Facility Name & ID Number Burgess Square Healthcare Ctr # 0029199 Report Period Beginning: 01/01/10 Ending: 12/31/10

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17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

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9										9
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16										16
17										17
18										18
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22										22
23										23
24										24
25	TOTALS					$	$		$	25

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Fax Number ( )

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Burgess Square Healthcare Ctr # 0029199 Report Period Beginning: 01/01/10 Ending: 12/31/10

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Baytree Lease		X	Phone Lease	$1,773.53	06/30/08	$ 78,637	$ 45,433	06/30/2013	12.61%	$ 6,741	1
2	TKG Lease		X	Satellite Dish	$1,143.29	10/01/08	43,807	28,998	09/20/2013	19.57%	6,467	2
3	Boyd energy		X	Note Payable	$2,722.00	05/26/10	61,665	48,055	5/26/2010	06.67%	1,904	3
4	Shael Bellows As Agent		X	Mortgage Paybale				6,157,862		10.75%	363,941	4
5	See Supplemental Schedule											5
	Working Capital											
6	Town Center Bank		X	Line of Credit				443,000		5.00%	29,312	6
7	Town Center Bank		X	Line of Credit				303,000			6,978	7
8	See Supplemental Schedule											8
9	TOTAL Facility Related				$5,638.82		$ 184,108	$ 7,026,347			$ 415,342	9
	B. Non-Facility Related*											
10	Interest Income		X								(3,520)	10
11												11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (3,520)	14
15	TOTALS (line 9+line14)						$ 184,108	$ 7,026,347			$ 411,822	15

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Burgess Square Healthcare Ctr # 0029199 Report Period Beginning: 01/01/10 Ending: 12/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Burgess Square Healthcare Ctr # 0029199 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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.	$	52,000	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.)	$	122,255	2
3. Under or (over) accrual (line 2 minus line 1).	$	70,255	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	$	55,500	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.	$	125,755	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	104,181	8
	2006	112,757	9
	2007	113,181	10
	2008	118,379	11
	2009	122,255	12

Beginning Accrual Adjusted Due to Building Purchase Mid Year.

2010 R/E Tax Accrual = 2009 R/E Tax $122,255 x 1.03 = $125,500 -$70,000 Bldg Co Purchase= $55,500

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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Burgess Square Healthcare Ctr COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0029199

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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.	09-15-107-044	Long Term Care Facility	$ 122,255.42	$ 122,255.42
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 122,255.42	$ 122,255.42

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 & 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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 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 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2008 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Burgess Square Healthcare Ctr COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0029199

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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 _____ NO

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

C. **Tax Bills**

Attach a copy of the original 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 Burgess Square Healthcare Ctr # 0029199 Report Period Beginning: 01/01/10 Ending: 12/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 57,000 B. General Construction Type: Exterior Brick Frame Steel Structure Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (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. [X] (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).

N/A

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	Land	57,000	2010	$ 654,000	1
2					2
3	TOTALS	57,000		$ 654,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Burgess Square Healthcare Ctr # 0029199 Report Period Beginning: 01/01/10 Ending: 12/31/10

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					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1985	86,486		20			86,486	9
10	Various			1986	87,317		20			87,317	10
11	Various			1987	10,202		20	324	324	7,598	11
12	Various			1988	11,485		20	365	365	8,188	12
13	Various			1989	25,270		20	802	802	17,215	13
14	Various			1990	52,220		20	1,657	1,657	33,916	14
15	Various			1991	27,798		20	883	883	17,172	15
16	Various			1992	12,659		20	402	402	7,418	16
17	Various			1993	342,712		20	8,787	8,787	151,339	17
18	Various			1994	16,249		20	417	417	6,857	18
19	Various			1995	20,503		20	526	526	8,127	19
20	Various			1996	23,823		20	611	611	8,832	20
21	Various			1997	29,589		20	759	759	10,211	21
22	Various			1998	36,702		20	941	941	11,724	22
23	Various			1999	88,002		20	2,256	2,256	25,856	23
24	Various			2000	184,195		20	4,723	4,723	49,513	24
25	Various			2001	81,564		20	1,979	1,979	18,806	25
26	Various			2002	22,857		20	1,143	1,143	9,238	26
27	Various			2003	16,608		20	830	830	5,882	27
28	Various			2004	22,150		20	1,108	1,108	7,199	28
29	Various			2006	51,681		20	2,584	2,584	10,552	29
30											30
31											31
32											32
33											33
34											34
35											35
36											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

Facility Name & ID Number Burgess Square Healthcare Ctr # 0029199 Report Period Beginning: 01/01/10 Ending: 12/31/10

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			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)			69,173			(69,173)		67
68	Related Party Allocations (Pages 12H & 12I)								68
69	Financial Statement Depreciation			397,787			(397,787)		69
70	TOTAL (lines 4 thru 69)		$ 1,250,072	$ 466,960		$ 31,096	$ (435,864)	$ 589,445	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Burgess Square Healthcare Ctr # 0029199 Report Period Beginning: 01/01/10 Ending: 12/31/10

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		$ 1,250,072	$ 466,960		$ 31,096	$ (435,864)	$ 589,445	1
2	Concrete Replacement	2007	27,425		20	1,828	1,828	6,399	2
3	Flooring	2007	4,697		20	235	235	724	3
4	Wallcovering	2007	8,646		20	432	432	1,333	4
5	Blinds, Shears, Valances	2007	8,183		20	409	409	1,262	5
6	Design / Architect Fees	2007	16,982		20	849	849	2,618	6
7	Wall Work, Ceiling, Floor Work, Plumbing, Electr	2007	73,683		20	3,684	3,684	11,359	7
8	Plumbing Fixtures	2007	5,901		20	295	295	910	8
9	Cabinets & Counter Tops	2007	27,000		20	1,350	1,350	4,163	9
10	Automatic Door System Renovation	2008	10,000		20	500	500	1,417	10
11	Land Improvements	2008	14,800		20	987	987	2,549	11
12	Leasehold Improvements	2008	19,329		20	966	966	2,738	12
13	Carpeting	2008	2,895		20	414	414	1,241	13
14	Leasehold Improvements	2008	3,141		20	157	157	366	14
15	Equipment - Telephone System	2008	69,724		20	13,945	13,945	36,024	15
16	Sign	2008	13,659		20	911	911	2,049	16
17	7.5 Ton Rooftop Unit	2008	4,715		20	236	236	511	17
18	Electrical Work	2008	2,790		20	186	186	465	18
19	Landscaping	2008	5,300		20	353	353	883	19
20	Black-Top Parking	2008	10,000		20	667	667	1,667	20
21	Chart Towers And Counter Top	2008	12,000		20	2,400	2,400	6,800	21
22	Vinyl Tile	2008	279		20	56	56	158	22
23	Bookcases	2008	10,000		20	2,000	2,000	5,667	23
24	Nurse'S Station First Floor Design	2008	7,669		20	1,534	1,534	4,346	24
25	Vinyl Tile	2008	3,571		20	714	714	2,023	25
26	Vinyl Cove Base	2008	1,010		20	202	202	572	26
27	Ceramic Tile	2008	1,717		20	115	115	286	27
28	Grout And Brushed Aluminum	2008	168		20	11	11	28	28
29	Wallpaper & Floor Removal	2008	1,370		20	91	91	228	29
30	Temp Wall	2008	460		20	31	31	77	30
31	Consulting On Remodel	2008	1,080		20	72	72	180	31
32	Dry Wall	2008	3,140		20	209	209	523	32
33	Carpentry Work	2008	1,720		20	344	344	975	33
34	TOTAL (lines 1 thru 33)		$ 1,623,126	$ 466,960		$ 67,278	$ (399,682)	$ 689,987	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Burgess Square Healthcare Ctr # 0029199 Report Period Beginning: 01/01/10 Ending: 12/31/10

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		$ 1,623,126	$ 466,960		$ 67,278	$ (399,682)	$ 689,987	1
2	Flooring Installation	2008	24,500		20	4,900	4,900	13,883	2
3	Electrical Work	2008	2,000		20	133	133	333	3
4	Vinyl Base	2008	63		20	13	13	36	4
5	Corner Guards Elevator Entry	2008	514		20	26	26	73	5
6	Ceramic Tile	2008	156		20	10	10	26	6
7	Construction Supplies	2008	304		20	61	61	172	7
8	Ceramic Tile - Porch	2008	807		20	40	40	114	8
9	Wood Blinds	2008	315		20	63	63	178	9
10	Valance	2008	844		20	169	169	478	10
11	Staining & Wall Repairs	2008	1,891		20	126	126	315	11
12	Painting And Repairs	2008	3,290		20	219	219	548	12
13	Carpentry	2008	1,940		20	388	388	1,099	13
14	Ceramic Floor Entrance	2008	1,323		20	88	88	220	14
15	Wall Tile Front Porch	2008	400		20	20	20	57	15
16	Electrical Work	2008	1,920		20	128	128	320	16
17	Thermopane Glass	2008	908		20	45	45	129	17
18	Paint Foyer & Halls	2008	396		20	26	26	66	18
19	Ceiling Parts	2008	294		20	15	15	42	19
20	Ibond Adhesive	2008	89		20	18	18	50	20
21	Vinyl Cove Base	2008	206		20	41	41	117	21
22	Vinyl Flooring	2008	126		20	25	25	72	22
23	Cabinets	2008	5,600		20	1,120	1,120	3,173	23
24	Aluminum Sign On Stone Wall	2008	1,810		20	362	362	1,026	24
25	Painting Repairs	2008	3,233		20	216	216	539	25
26	Painting Halls & Foyer	2008	455		20	30	30	76	26
27	Carpentry Work Cabinets	2008	1,440		20	288	288	816	27
28	Carpentry Work	2008	180		20	36	36	102	28
29	Elevator Work	2008	145		20	7	7	21	29
30	Vinyl Wall Strip Entry	2008	49		20	10	10	28	30
31	Employee Bathrooms	2008	2,650		20	133	133	375	31
32	Design Fees - 15 Yrs	2008	4,388		20	293	293	731	32
33	Design Fees - 39 Yrs	2008	2,573		20	129	129	365	33
34	TOTAL (lines 1 thru 33)		$ 1,687,933	$ 466,960		$ 76,457	$ (390,503)	$ 715,567	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Burgess Square Healthcare Ctr # 0029199 Report Period Beginning: 01/01/10 Ending: 12/31/10

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		$ 1,687,933	$ 466,960		$ 76,457	$ (390,503)	$ 715,567	1
2	Building Outside Painting	2008	9,500		20	475	475	1,188	2
3	Wallpaper Border	2008	3,645		20	182	182	395	3
4	Elia Paving Co.	2008	4,100		20	205	205	444	4
5	Tiling, Painting, Toilets, Sinks	2008	2,727		20	136	136	341	5
6	Sign Lights Installation - Related To Sign $13,659	2008	2,200		20	110	110	229	6
7	Sing Wiring - Related To Sign $13,659	2008	300		20	15	15	31	7
8	Vinyl Flooring	2009	10,660		20	2,132	2,132	4,264	8
9	Lounge Area - Paint Walls	2009	4,860		20	324	324	486	9
10	Construction	2009	85,314		20	5,690	5,690	8,531	10
11	Ceramic Tiles	2009	3,568		20	238	238	357	11
12	Decorating	2009	3,075		20	205	205	308	12
13	Wallpaper	2009	14,549		20	2,910	2,910	4,850	13
14	Carpeting	2009	1,869		20	374	374	685	14
15	Liftomatic - Elevator Renovation	2009	46,500		20	2,325	2,325	3,294	15
16	Pt Conversion Remodel - Lr Hein	2009	101,543		20	6,773	6,773	10,154	16
17	Decorating-Sms	2009	2,553		20	170	170	255	17
18	Decorating-Sms	2009	1,246		20	83	83	125	18
19	Engineering Services	2009	343		20	23	23	34	19
20	Construction For Shower Room	2009	26,694		20	1,335	1,335	2,002	20
21	Decorating S.M.S. - Wallpaper	2009	4,176		20	835	835	1,183	21
22	Roofs	2009	20,775		20	1,039	1,039	1,472	22
23	Secure Care Elevator	2009	4,300		20	215	215	305	23
24	Remodel Of Elevator	2009	4,800		20	240	240	340	24
25	D.L. Couch Wallcoverings	2009	2,429		20	486	486	688	25
26	Decorating S.M.S.	2009	5,444		20	363	363	544	26
27	Electrical Services - Elevator	2009	3,775		20	189	189	252	27
28	Heated Air Curtain	2009	3,950		20	790	790	1,053	28
29	Simplex Grinnell - Fire Alarm	2009	9,992		20	666	666	999	29
30	Csi - Hvac	2009	6,800		20	454	454	680	30
31	Parking Space- Indian Ridge	2009	7,900		20	527	527	614	31
32	Boyd Electric	2009	1,440		20	96	96	144	32
33	Pt Conversion Additional Costs - L.R. Hein	2009	23,699		20	1,185	1,185	1,777	33
34	TOTAL (lines 1 thru 33)		$ 2,112,659	$ 466,960		$ 107,247	$ (359,713)	$ 763,592	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Burgess Square Healthcare Ctr # 0029199 Report Period Beginning: 01/01/10 Ending: 12/31/10

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		$ 2,112,659	$ 466,960		$ 107,247	$ (359,713)	$ 763,592	1
2	Rtu	2009	8,662		20	578	578	866	2
3	Lsc Life Safety Code Compliance	2009	2,700		20	135	135	270	3
4	500 Wing - Wallpaper, Installation & Supplies	2009	16,430		20	822	822	1,369	4
5	500 Wing - Carpet Removal & Vinyl Installation	2009	7,979		20	399	399	765	5
6	500 Wing - Bathroom, Tile, Faucet, Sinks, Toilets, Rails, & Supplie	2009	8,764		20	438	438	767	6
7	500 Wing - Cabinets, Granite, Lighting Fixtures	2009	2,892		20	145	145	265	7
8	1St & 2Nd Floor - Wallpaper Removal & Installation	2009	10,910		20	546	546	909	8
9	1St & 2Nd Floor - Architecutre Fees	2009	4,885		20	244	244	448	9
10	1St & 2Nd - 2' Blinds	2009	2,977		20	149	149	260	10
11	500 Wing - 2' Blinds	2009	3,891		20	195	195	357	11
12	Decorating - Wallpaper & Painting	2009	2,896		20	145	145	181	12
13	Cove Base, Carpet Tiles & Construction	2009	3,283		20	164	164	192	13
14	Thermostatic Valve	2010	2,950		20	98	98	98	14
15	200 Wing - Electrical Work	2010	3,780		20	126	126	126	15
16	200 Wing - Electrical Conduit	2010	1,850		20	62	62	62	16
17	200 Wing Flooring - Wood Flooring	2010	775		20	16	16	16	17
18	Hallway Lighting	2010	3,000		20	61	61	61	18
19	Hardwood Flooring	2010	14,928		20	303	303	303	19
20	200 Wing Flooring - Cover Base	2010	1,332		20	44	44	44	20
21	Wallpaper Border Floral	2010	6,271		20	941	941	941	21
22	Parking Lot Blacktop Repair & Asphalt	2010	47,400		20	2,107	2,107	2,107	22
23	Stone Façade	2010	11,300		20	504	504	504	23
24	Roofing, Flashing, & Drains	2010	9,000		20	300	300	300	24
25	Exterior Painting & Repair	2010	6,500		20	216	216	216	25
26	Flooring	2010	9,840		20	1,148	1,148	1,148	26
27	Supply & Install Daltile In Bathrooms	2010	2,038		20	68	68	68	27
28	200 Wing Flooring - Rapid Thin Set	2010	578		20	19	19	19	28
29	200 Wing Flooring - Wood & Tile Flooring, Adhesive	2010	8,657		20	288	288	288	29
30	Castle Craft Products - Office Millwork	2010	2,971		20	99	99	99	30
31	Sms Exterior Paint	2010	4,908		20	163	163	163	31
32	Sms Bathroom Paint Work - 200 Hallway	2010	7,560		20	252	252	252	32
33	200 Wing Flooring - Cove Base & Vynil Flooring	2010	2,001		20	67	67	67	33
34	TOTAL (lines 1 thru 33)		$ 2,336,567	$ 466,960		$ 118,087	$ (348,873)	$ 777,122	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Burgess Square Healthcare Ctr # 0029199 Report Period Beginning: 01/01/10 Ending: 12/31/10

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		2,336,567			118,087	(348,873)	777,122	1
2	Office Carpet	2010	9,205		20	767	767	767	2
3	Painting	2010	4,230		20	88	88	88	3
4	Led Light Install	2010	5,800		20	121	121	121	4
5	Vynil Floor Replacement	2010	4,371		20	91	91	91	5
6	Electrical And Wiring	2010	13,865		20	347	347	347	6
7	Hallway Lighting	2010	7,509		20	40	40	40	7
8	Excavation Work	2010	9,500		20	40	40	40	8
9	Ductwork	2010	14,550		20	61	61	61	9
10	Craft Door Work	2010	10,476		20	44	44	44	10
11	Shower Work	2010	5,312		20	89	89	89	11
12	Supply & Instal Daltile In Bathrooms	2010	2,950		20	615	615	615	12
13	Reception Desk Repair & Retemplating Of Tops 2Nd Floor	2010	12,300		20	615	615	615	13
14	New Doors, Drawers Faces & Tops For Lunch Buffet Area	2010	3,768		20	188	188	188	14
15	2Nd Flr: Cabinets, Breaker Box Cover, Elevator Interior	2010	3,659		20	183	183	183	15
16	Doctor Office Remodel - Work Stations & Sliding Doors	2010	4,794		20	240	240	240	16
17	Suppressor Repair & Labor	2010	3,599		20	180	180	180	17
18	Bathroom Remodel - Sink, Toilets, Tower Bars & Faucets	2010	5,802		20	290	290	290	18
19	Steam Blower Repair	2010	2,982		20	149	149	149	19
20	Rago Electric- For Outside Coolers	2010	2,675		20	134	134	134	20
21	Plumbing Replacement & Reparis	2010	5,761		20	288	288	288	21
22	Landscaping Mulch & Installation	2010	2,766		20	138	138	138	22
23	Csi Elevator Exhauster Reapr & Replacement	2010	4,236		20	212	212	212	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34			2,476,678			123,005	(343,955)	782,041	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Burgess Square Healthcare Ctr # 0029199 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	Building Company Information		$	$		$		$	1
2	Buildings:								2
3	Facility Buidling - 07/14/2010	1970	5,886,000	69,173	39	1,774	(67,399)	1,774	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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	TOTAL (12F & 12G lines 1 thru 33)		$	$ 69,173		$	$	$	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Burgess Square Healthcare Ctr # 0029199 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	Related Party Information		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
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21									21
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Burgess Square Healthcare Ctr # 0029199 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	Related Party Information Continued								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		$	$		$	$	$	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Burgess Square Healthcare Ctr # 0029199 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	$ 410,765	$	$ 71,916	$ 71,916	10	$ 181,262	71
72	Current Year Purchases	126,767		17,468	17,468	10	17,468	72
73	Fully Depreciated Assets	581,200				10	581,200	73
74								74
75	TOTALS	$ 1,118,732	$	$ 89,383	$ 89,383		$ 779,930	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		AUTO	1998	$ 22,421	$	$	$	5	$ 22,421	76
77		USED BUS	2009	10,000		1,913	1,913	5	2,985	77
78										78
79										79
80	TOTALS			$ 32,421	$	$ 1,913	$ 1,913		$ 25,406	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)	$ 4,281,830	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 466,960	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 214,302	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (252,658)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,587,376	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	Remodel of 2 bath's to Spas	$ 36,112	92
93			93
94			94
95		$ 36,112	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 Burgess Square Healthcare Ctr # 0029199 Report Period Beginning: 01/01/10 Ending: 12/31/10

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Camelot Healthcare Center
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. [x] 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:		211		$ 302,123			3
4	Additions				1,921	Storage		4
5								5
6								6
7	TOTAL		211		$ 304,044 **			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: *

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 [ ] NO
16. Rental Amount for movable equipment: $ 10,373 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Burgess Square Healthcare Ctr # 0029199 Report Period Beginning: 01/01/10 Ending: 12/31/10

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?
   - [ ] YES
   - [X] 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 [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Burgess Square Healthcare Ctr

STATE OF ILLINOIS
0029199 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	39 - 01	hrs	$ 438,719		$ 88,912	$		$ 527,631	1
2	Licensed Speech and Language Development Therapist	39 - 01	hrs	44,207		1,575			45,782	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	565,458		9,183			574,641	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				679,159		679,159	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental						82,652		82,652	13
14	TOTAL			$ 1,048,384		$ 99,670	$ 761,811		$ 1,909,865	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Burgess Square Healthcare Ctr # 0029199 Report Period Beginning: 01/01/10 Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 606,246	$ 606,952	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,696,303	1,696,303	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	316,914	316,914	6
7	Other Prepaid Expenses	68,666	68,666	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	31,202	31,202	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,719,331	$ 2,720,037	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		654,000	13
14	Buildings, at Historical Cost		5,886,000	14
15	Leasehold Improvements, at Historical Cost	2,158,783	2,158,783	15
16	Equipment, at Historical Cost	1,428,596	1,428,596	16
17	Accumulated Depreciation (book methods)	(2,300,236)	(2,369,409)	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): See Attached Schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,287,143	$ 7,757,970	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,006,474	$ 10,478,007	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 453,573	$ 453,573	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	507,894	810,894	29
30	Accrued Salaries Payable	271,212	271,212	30
31	Accrued Taxes Payable (excluding real estate taxes)	22,648	22,648	31
32	Accrued Real Estate Taxes(Sch.IX-B)	125,500	55,500	32
33	Accrued Interest Payable	3,456	3,456	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	6,000	6,000	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	346,305	346,305	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,736,588	$ 1,969,588	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	57,593	57,593	39
40	Mortgage Payable		6,157,862	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 57,593	$ 6,215,455	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,794,181	$ 8,185,043	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,212,293	$ 2,292,964	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,006,474	$ 10,478,007	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Burgess Square Healthcare Ctr # 0029199 Report Period Beginning: 01/01/10 Ending: 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,410,810	1
2	Restatements (describe):		2
3	**Depreciation**	2,377	3
4	**Deposits**	(21,426)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,391,761	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(53,438)	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	(126,030)	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)**	$ (179,468)	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)**	$ 2,212,293	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Burgess Square Healthcare Ctr # 0029199 Report Period Beginning: 01/01/10 Ending: 12/31/10

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 15,968,010	1
2	Discounts and Allowances for all Levels	(5,246,605)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,721,405	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,115,058	6
7	Oxygen	38,336	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 4,153,394	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,206,963	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	87,562	19
20	Radiology and X-Ray	30,875	20
21	Other Medical Services	418,048	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,743,448	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,521	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,521	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	2,926	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,926	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 16,624,694	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,109,286	31
32	Health Care	6,400,192	32
33	General Administration	4,653,039	33
	B. Capital Expense		
34	Ownership	1,404,247	34
	C. Ancillary Expense		
35	Special Cost Centers	1,997,207	35
36	Provider Participation Fee	114,161	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 16,678,132	40
41	**Income before Income Taxes (line 30 minus line 40)****	(53,438)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (53,438)	43

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

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

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

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

Facility Name & ID Number Burgess Square Healthcare Ctr # 0029199 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,579	2,079	$ 100,156	$ 48.18	1
2	Assistant Director of Nursing	4,030	4,615	124,422	26.96	2
3	Registered Nurses	47,948	55,516	1,686,580	30.38	3
4	Licensed Practical Nurses	28,059	32,488	986,991	30.38	4
5	CNAs & Orderlies	146,552	152,403	1,798,351	11.80	5
6	CNA Trainees					6
7	Licensed Therapist	24,316	26,643	1,048,384	39.35	7
8	Rehab/Therapy Aides	11,143	11,143	205,938	18.48	8
9	Activity Director	1,956	2,127	33,385	15.69	9
10	Activity Assistants	13,854	14,948	158,736	10.62	10
11	Social Service Workers	6,609	7,589	199,441	26.28	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	4,676	5,282	70,324	13.31	14
15	Cook Helpers/Assistants	33,394	36,210	341,831	9.44	15
16	Dishwashers					16
17	Maintenance Workers	3,408	4,376	109,681	25.06	17
18	Housekeepers	29,490	33,759	387,482	11.48	18
19	Laundry	6,282	7,346	82,466	11.23	19
20	Administrator	1,888	2,080	124,529	59.87	20
21	Assistant Administrator					21
22	Other Administrative	2,080	2,080	114,112	54.86	22
23	Office Manager					23
24	Clerical	16,177	17,813	418,060	23.47	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	3,982	4,371	71,250	16.30	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	11,005	11,731	248,692	21.20	33
34	TOTAL (lines 1 - 33)	398,427	434,600	$ 8,310,811 *	$ 19.12	34

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		$		35
36	Medical Director	Monthly	59,250	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	4,800	10-03	38
39	Pharmacist Consultant	Monthly	10,029	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	50	2,031	11-03	44
45	Social Service Consultant	59	1,357	12-03	45
46	Other(specify)				46
47	Physician Services	Monthly	54,074	10-03	47
48					48
49	TOTAL (lines 35 - 48)	109	$ 131,541		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	42	$ 2,456	10-03	50
51	Licensed Practical Nurses	749	31,097	10-03	51
52	Certified Nurse Assistants/Aides	104	1,558	10-03	52
53	TOTAL (lines 50 - 52)	895	$ 35,111		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number Burgess Square Healthcare Ctr # 0029199 Report Period Beginning: 01/01/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
John F. Vrba	Administrator	0	$ 124,530
Anthony Shreiber	Administrative	0	114,112
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 238,641

B. Administrative - Other

Description	Amount
Management Fee - United Care	$ 1,055,500
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,055,500
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost Ruttenberg	Accounting	$ 73,960
Wildman, Harrold, Allen & Dixon	Legal	1,307
Foote, Meyers, Mielk & Flowers	Legal	965
Non-Allowable Legal	(ADJ Pg. 5A)	153,143
E-Health Data Solutions	Data Processing	8,424
Accumed	Data Processing	1,950
ADP	Payroll	100,802
2401 Incorporated	Architect Fees	1,094
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 341,645

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 212,564
Unemployment Compensation Insurance	46,176
FICA Taxes	599,831
Employee Health Insurance	714,245
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension Fund	44,371
Employee Benefits	16,872
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,634,060

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

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	3,140
(Indicate # of checks performed 230)	3,710
Patient Background Checks 401	6,416
Advertising & Promotion	11,532
Yellow Pages	282
Dues & Subscriptions	19,064
Licenses & Fees	6,696
Less: Public Relations Expense	(10,360)
Non-allowable advertising	(11,533)
Yellow page advertising	(282)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 28,664

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	16,854
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 16,854

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Burgess Square Healthcare Ctr # 0029199 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Burgess Square Healthcare Ctr # 0029199 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $16,568.86**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** 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?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **123,554** Line **10-02**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

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

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **111,143**
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. $ Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.