FOR BHF USE

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

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.

I. IDPH License ID Number: 0035469

Facility Name: Walter Lawson Children's Home

Address: 1820 Walter Lawson Drive (Number) Loves Park (City) 61111 (Zip Code)

County: Winnebago

Telephone Number: (815) 633-6636 **Fax #** (815) 633-6387

HFS ID Number:

Date of Initial License for Current Owners: 08/15/89

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501 (c)(3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Kylie Waters Whipple **Telephone Number:** (859) 255-0075
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 7/1/09 to 6/30/10 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) Kylie Waters Whipple
(Title) Controller - Medical Rehabilitation Centers, Inc.

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Rick Mittman, Senior Managing Consultant
(Firm Name & Address) BKD, LLP, 201 North Illinois Street, Suit 700, Indianapolis, IN 46244
(Telephone) (317) 383-4000 Fax # (317) 383-4200

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**

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 7/1/09 Ending: 6/30/10

III. STATISTICAL DATA

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

	1 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		Skilled (SNF)			1
2	99	Skilled Pediatric (SNF/PED)	99	36,135	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	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					8
9	SNF/PED	32,853	9		32,862	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	32,853	9		32,862	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.94%

D. How many bed-hold days during this year were paid by the Department?
733 (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 [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 8/15/89

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 8/15/89 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified 0 and days of care provided N/A

Medicare Intermediary Not Applicable

IV. ACCOUNTING BASIS

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

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

Tax Year: 6/30/10 Fiscal Year: 6/30/10

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

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 7/1/09 Ending: 6/30/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	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	184,961	7,428	14,456	206,845	12,349	219,194	(69,103)	150,091			1
2	Food Purchase		262,107		262,107		262,107		262,107			2
3	Housekeeping	187,641	18,786	692	207,119		207,119		207,119			3
4	Laundry	75,696	5,011	305	81,012		81,012		81,012			4
5	Heat and Other Utilities			82,723	82,723	1,162	83,885		83,885			5
6	Maintenance	43,310	8,759	47,076	99,145	1,762	100,907		100,907			6
7	Other (specify):*											7
8	TOTAL General Services	491,608	302,091	145,252	938,951	15,273	954,224	(69,103)	885,121			8
	B. Health Care and Programs											
9	Medical Director			12,500	12,500		12,500		12,500			9
10	Nursing and Medical Records	2,858,671	167,129	19,068	3,044,868	19,441	3,064,309		3,064,309			10
10a	Therapy	5,640		41,650	47,290		47,290		47,290			10a
11	Activities	12,273	332		12,605		12,605		12,605			11
12	Social Services											12
13	CNA Training											13
14	Program Transportation		2,076		2,076		2,076		2,076			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,876,584	169,537	73,218	3,119,339	19,441	3,138,780		3,138,780			16
	C. General Administration											
17	Administrative	144,979		201,086	346,065	(207,018)	139,047	5,932	144,979			17
18	Directors Fees					21,008	21,008		21,008			18
19	Professional Services			607,330	607,330	78,213	685,543		685,543			19
20	Dues, Fees, Subscriptions & Promotions			8,129	8,129	376	8,505	(322)	8,183			20
21	Clerical & General Office Expenses	182,761	10,597	32,801	226,159	46,341	272,500	(743)	271,757			21
22	Employee Benefits & Payroll Taxes			766,663	766,663	11,901	778,564		778,564			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,101	8,101	160	8,261		8,261			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			53,588	53,588		53,588		53,588			26
27	Other (specify):* Bad Debt			40,217	40,217		40,217	(40,217)				27
28	TOTAL General Administration	327,740	10,597	1,717,915	2,056,252	(49,019)	2,007,233	(35,350)	1,971,883			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,695,932	482,225	1,936,385	6,114,542	(14,305)	6,100,237	(104,453)	5,995,784			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Walter Lawson Children's Home #0035469 Report Period Beginning: 7/1/09 Ending: 6/30/10

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			227,391	227,391	179	227,570		227,570			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			684,643	684,643	12,581	697,224	(81,552)	615,672			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds					1,922	1,922		1,922			34
35	Rent-Equipment & Vehicles			7,046	7,046	(377)	6,669		6,669			35
36	Other (specify):* Amortization			14,492	14,492		14,492	(1,573)	12,919			36
37	TOTAL Ownership			933,572	933,572	14,305	947,877	(83,125)	864,752			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			341,340	341,340		341,340		341,340			42
43	Other (specify):* Edu/Day Training	1,009,245	256	6,144	1,015,645		1,015,645		1,015,645			43
44	TOTAL Special Cost Centers	1,009,245	256	347,484	1,356,985		1,356,985		1,356,985			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,705,177	482,481	3,217,441	8,405,099		8,405,099	(187,578)	8,217,521			45

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

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 7/1/09 Ending: 6/30/10

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				9
10	Interest and Other Investment Income	2,321	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(40,217)	27		24
25	Fund Raising, Advertising and Promotional	(322)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(155,292)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (193,510)		$	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)	5,932		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 5,932		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (187,578)		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.		X	$		38
39		X		SNF/PED		39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44			X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Walter Lawson Children's Home

ID# 0035469

Report Period Beginning: 7/1/09

Ending: 6/30/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Amortization - Goodwill	$ (13,684)	36	1
2	Non-allowable bond acquisition costs	12,111	36	2
3	Non-allowable interest expense	(83,873)	32	3
4	Miscellaneous Expense	(743)	21	4
5	Meals Revenue	(69,103)	1	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(155,292)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Walter Lawson Children's Home # 0035469 **Report Period Beginning:** 7/1/09 **Ending:** 6/30/10

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	(69,103)	0	0	0	0	0	0	0	0	0	0	(69,103)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(69,103)	0	0	0	0	0	0	0	0	0	0	(69,103)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	5,932	0	0	0	0	0	0	0	0	0	5,932	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(322)	0	0	0	0	0	0	0	0	0	0	(322)	20
21	Clerical & General Office Expenses	(743)	0	0	0	0	0	0	0	0	0	0	(743)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(40,217)	0	0	0	0	0	0	0	0	0	0	(40,217)	27
28	**TOTAL General Administration**	(41,282)	5,932	0	0	0	0	0	0	0	0	0	(35,350)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(110,385)	5,932	0	0	0	0	0	0	0	0	0	(104,453)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Walter Lawson Children's Home # 0035469 **Report Period Beginning:** 7/1/09 **Ending:** 6/30/10

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(81,552)	0	0	0	0	0	0	0	0	0	0	(81,552)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(1,573)	0	0	0	0	0	0	0	0	0	0	(1,573)	36
37	**TOTAL Ownership**	(83,125)	0	0	0	0	0	0	0	0	0	0	(83,125)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(193,510)	5,932	0	0	0	0	0	0	0	0	0	(187,578)	45

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 7/1/09 Ending: 6/30/10

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		Swann Special Care Center	Champaign			
		Exceptional Care & Training Center	Sterling			
		Vernon Manor Children's Home	Wabash, Indiana			
		Richland-Bean Blossom HCC	Ellettsville, Indiana			
		Exceptional Living Centers of Brazil	Brazil, Indiana			
		Clay County Nursing Center	Brazil, Indiana			
		Randolph Nursing Home	Winchester, Indiana			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	17	Corporate Expense	$ 201,086	Hoosier Care, Inc.	100.00%	$ 207,018	$ 5,932	1
2	V								2
3	V				Note: See Schedule VIII of allocation of cost per column 7.				3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 201,086			$ 207,018	$ * 5,932	14

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

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 7/1/09 Ending: 6/30/10

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	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 Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	Bruce Hutson, M.D.	Director	Board Meetings	0.00	11,056			Director Fees	$ 2,567	18.8	1
2	Stephen Wood	Director	Board Meetings	0.00	53,564			Director Fees	12,433	18.8	2
3	John Gillmor	Director	Board Meetings	0.00	15,243			Director Fees	3,539	18.8	3
4	John Foos	Director	Board Meetings	0.00	10,637			Director Fees	2,469	18.8	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 21,008		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 Walter Lawson Children's Home # 0035469 Report Period Beginning: 7/1/09 Ending: 6/30/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Hoosier Care, Inc.
Street Address: 535 West Second, Suite 105
City / State / Zip Code: Lexington, Kentucky 40508
Phone Number: (859) 255-0075
Fax Number: (859) 281-5150

	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	Dietary	Revenue	45,772,634	8	$ 67,937	$ 0	8,623,663	$ 12,799	1
2	5	Heat & Other Utilities	Revenue	45,772,634	8	6,168	0	8,623,663	1,162	2
3	6	Maintenance	Revenue	45,772,634	8	5,340	0	8,623,663	1,006	3
4	10	Nursing / Medical Records	Revenue	45,772,634	8	103,189	0	8,623,663	19,441	4
5	18	Director's Fees	Revenue	45,772,634	8	111,508	0	8,623,663	21,008	5
6	19	Professional Fees	Revenue	45,772,634	8	415,140	0	8,623,663	78,213	6
7	20	Fees, Subscription & Promotion	Revenue	45,772,634	8	1,994	0	8,623,663	376	7
8	21	Clerical & General Office Exp.	Revenue	45,772,634	8	245,593	0	8,623,663	46,270	8
9	22	Emp. Benefits & Payroll Tax	Revenue	45,772,634	8	63,169	0	8,623,663	11,901	9
10	24	Travel & Seminar	Revenue	45,772,634	8	850	0	8,623,663	160	10
11	30	Depreciation	Revenue	45,772,634	8	950	0	8,623,663	179	11
12	32	Interest Expense	Revenue	45,772,634	8	66,775	0	8,623,663	12,581	12
13	34	Rent - Facility	Revenue	45,772,634	8	10,200	0	8,623,663	1,922	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,098,813	$		$ 207,018	25

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 7/1/09 Ending: 6/30/10

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	City of Loves Park - 1999A		X	Purchase of Facility	Varies	7/8/99	$ 5,500,000	$ 4,900,000	06/01/2034	7.1250	$ 352,512	1
2	City of Loves Park - 1999B		X	Purchase of Facility	Varies	7/8/99	250,000	175,000	06/02/2019	10.5000	19,163	2
3	Hoosier Care Investments, LLC	X		Addition to Facility	$25,493.00	3/15/07	3,000,000	2,824,895	04/15/2027	8.0000	229,095	3
4												4
5												5
	Working Capital											
6	Corporate Allocation										12,581	6
7												7
8												8
9	TOTAL Facility Related				$25,493.00		$ 8,750,000	$ 7,899,895			$ 613,351	9
	B. Non-Facility Related*											
10	Debt Allocation		X	Purchase of Facility	Varies	7/8/99		1,142,644	Varies	Varies	83,873	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$ 1,142,644			$ 83,873	14
15	TOTALS (line 9+line14)						$ 8,750,000	$ 9,042,539			$ 697,224	15

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

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

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

Facility Name & ID Number Walter Lawson Children's Home **#** 0035469 **Report Period Beginning:** 7/1/09 **Ending:** 6/30/10

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	**None**	**8**
	2006		**9**
	2007		**10**
	2008		**11**
	2009		**12**

Note: The facility became exempt from property taxes starting 1/1/96

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	**13**
14	PLUS APPEAL COST FROM LINE 5	$	**14**
15	LESS REFUND FROM LINE 6	$	**15**
16	AMOUNT TO USE FOR RATE CALCULATION	$	**16**

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Walter Lawson Children's Home COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0035469

CONTACT PERSON REGARDING THIS REPORT Kylie Waters Whipple

TELEPHONE (859) 255-0075 FAX #: (859) 281-5150

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.	TAX EXEMPT		$	$
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 Walter Lawson Children's Home # 0035469 Report Period Beginning: 7/1/09 Ending: 6/30/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,782 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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).

None

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	SNF/PED	217,364	1989	$ 665,000	1
2			1997	19,428	2
3	TOTALS	217,364		$ 684,428	3

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 7/1/09 Ending: 6/30/10

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	93		1989	1971	$ 2,917,000	$ 63,425	10-40	$ 63,425	$	$ 1,706,640	4
5	6			2008	3,659,316	91,483	40	91,483		205,837	5
6											6
7											7
8											8
	Improvement Type**										
9	Roofing			1989	1,625		5			1,625	9
10	Carpeting			1990	936		3			936	10
11	Heater / A-C			1990	17,400		5			17,400	11
12	Improvements			1991	1,563		10			1,563	12
13	Water Heater			1991	961		10			961	13
14	Door Frame Molding			1991	527		10			527	14
15	Doors			1991	738		10			738	15
16	Water Heater			1992	1,749		10			1,749	16
17	Handrails			1992	584		10			584	17
18	Roofing			1992	2,258		10			2,258	18
19	Water Line			1992	755		10			755	19
20	Smoke Dampers			1993	2,400		10			2,400	20
21	Blacktop Driveway			1993	10,130		10			10,130	21
22	Install Duct Runs			1994	750		10			750	22
23	Remodel Laundry Room			1994	3,154		10			3,154	23
24	Weather-Stripping Replacement			1994	1,849		10			1,849	24
25	Remodel Laundry Room			1994	2,063		10			2,063	25
26	A/C Roof Top Unit			1994	8,985		10			8,985	26
27	Install Sump Pump and Man Hole			1994	3,200		10			3,200	27
28	Anti-Scald Valve			1995	696		10			696	28
29	Alarm Ansul System			1995	1,253		10			1,253	29
30	Garbage Disposal			1995	1,067		10			1,067	30
31	Water Booster System Replacement			1995	6,941		10			6,941	31
32	Carpet for Offices			1995	2,432		10			2,432	32
33	Strip/Seal North Parking Lot			1995	3,382		10			3,382	33
34	Additional Parking Spaces			1995	2,375		10			2,375	34
35	Replace Gutters & Down Spouts			1995	2,150		10			2,150	35
36	Install New Windows			1995	2,588		10			2,588	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 Walter Lawson Children's Home # 0035469 Report Period Beginning: 7/1/09 Ending: 6/30/10

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	Gazebo Building	1995	$ 1,676	$	10	$	$	$ 1,676	37
38	Tile Kitchen Floor	1996	5,187		10			5,187	38
39	Bi-Fold Mirror Doors	1996	699		10			699	39
40	Clear Theralite Window Panel	1996	730		10			730	40
41	Remodel Kitchen - Ceiling Tiles	1996	279		10			279	41
42	Install Water Heater	1996	4,981		10			4,981	42
43	Install Hatco Water Heater	1996	1,550		10			1,550	43
44	New Roof on West Entrance	1996	1,150		10			1,150	44
45	Install New Mixing Valve	1996	2,960		10			2,960	45
46	Service Sink	1996	644		10			644	46
47	Vinyl Replacement Windows	1996	1,725		10			1,725	47
48	Install Water Heater	1997	6,014		10			6,014	48
49	Shower Trolley	1997	10,924		10			10,924	49
50	Stonebridge Tile-Bathing Area	1997	666		10			666	50
51	Drain, Lines, Vent Shower Trolley	1997	1,340		10			1,340	51
52	Install 175 Watt Fixture	1997	1,427		10			1,427	52
53	Replace Temperature Control Board - A/C	1997	1,021		10			1,021	53
54	Water Circulation Pump	1997	675		10			675	54
55	Re-Roof North Wing, Gravel Roof	1997	27,597		10			27,597	55
56	Parking Lot	1997	9,898		10			9,898	56
57	Fence	1997	5,680		10			5,680	57
58	Dirt & Sod	1997	1,075		10			1,075	58
59	Reinstall AC Roof Top Unit	1997	2,975		10			2,975	59
60	Security System	1997	2,362		10			2,362	60
61	Hopper Service Sink	1997	660		10			660	61
62	Education Wing Project	1997	285,914	14,296	20	14,296		181,079	62
63	Grade & Sod	1998	520		10			520	63
64	Replace Blower Motor	1998	620		10			620	64
65	Pour New Concrete	1998	945		10			945	65
66	Install Emergency Generator	1998	85,329		10			85,329	66
67	Cabinets & Countertops	1998	788		10			788	67
68	Replace Inducer Motor	1998	837		10			837	68
69	Replace Heat Exchanger, Burners & Deflection Plate	1998	1,228		10			1,228	69
70	TOTAL (lines 4 thru 69)		$ 7,130,903	$ 169,204		$ 169,204	$	$ 2,362,229	70

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

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 7/1/09 Ending: 6/30/10

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		$ 7,130,903	$ 169,204		$ 169,204	$	$ 2,362,229	1
2	Install New Receptacle, Box & Separated Circuits	1998	1,639		10			1,639	2
3	Roof	1998	700		10			700	3
4	Install Thermaltite Window	1998	570		10			570	4
5	Blacktop New Parking Lot and Driveway	1998	9,752		10			9,752	5
6	Install New Aluminum Siding/Install New Gutter	1998	1,397		10			1,397	6
7	Replace Gas Valve, Thermostats, Circuit Board, Ignitor	1998	1,008		10			1,008	7
8	Install New Roof-Top Heating / Air Conditioning Unit	1999	4,340		10			4,340	8
9	Re-Tile Bathtub Room Floor and Walls	1999	2,080		10			2,080	9
10	New Bathtub, Install Drain, Vent, Water Lines	1999	1,780		10			1,780	10
11	Install New Sink	1999	676		10			676	11
12	Heat Exchanger	1999	912		10			912	12
13	Roof-Top Unit Replace Motor	1999	730		10			730	13
14	Tear Off and Replace Roof	1999	2,500	125	20	125		1,375	14
15	Install New Roof Shingles, Facia Boards & Vents	1999	3,727	186	20	186		1,987	15
16	Furnish and Install True 2-Door Freezer	1999	3,265	218	15	218		2,323	16
17	Install New Heat Exchanger	2000	730	49	15	49		512	17
18	Extension and Enlargement of Sewer System Pipes	2000	1,804	120	15	120		1,262	18
19	Installed New 50 Gallon Water Heater	2000	918	61	15	61		632	19
20	New Toshiba Strata Digital Telephone System	2000	3,264	218	10	218		3,264	20
21	New Toshiba Strata Digital Telephone System	2000	6,528	435	10	435		6,528	21
22	New Toshiba Strata Digital Telephone System	2000	1,478	98	10	98		1,478	22
23	Tear Off and Replace North Flat Roof	2000	1,147	57	20	57		582	23
24	Replace Concrete at Pavillion	2000	2,700	180	15	180		1,770	24
25	Cement Walk & Landscaping to Prevent Flooding	2000	900	60	15	60		585	25
26	Seal and Stripe Parking Lot	2000	1,600	160	10	160		1,560	26
27	Install Two RPZ Backflow Preventor	2000	2,445	163	15	163		1,603	27
28	Fire Sprinkler System Installation	2001	37,774	1,511	25	1,511		14,354	28
29	New Laundry Room Air Intake Filter	2001	623	25	25	25		231	29
30	Sprinkler System Valve	2001	2,200	88	25	88		807	30
31	Duro-Last Roof System Installation	2001	40,846	1,634	25	1,634		14,977	31
32	Trolly Shower Mattress	2001	900	90	10	90		810	32
33	New Door	2001	2,085	139	15	139		1,239	33
34	TOTAL (lines 1 thru 33)		$ 7,273,921	$ 174,821		$ 174,821	$	$ 2,445,692	34

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

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 7/1/09 Ending: 6/30/10

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		$ 7,273,921	$ 174,821		$ 174,821	$	$ 2,445,692	1
2	Booster Pump	2001	4,837	322	15	322		2,767	2
3	Cornice	2001	859	57	15	57		505	3
4	Nurse's Station	2001	6,594	440	15	440		3,847	4
5	Foyer Carpet	2001	2,341	234	10	234		2,048	5
6	Internet Wiring	2002	2,341	156	15	156		1,313	6
7	Install Steel Door Frame	2002	1,485	99	15	99		776	7
8	New Heat Exchanger	2002	2,818	188	15	188		1,472	8
9	Gutters & Downspouts	2002	900	90	10	90		705	9
10	Internal Parts Tempering	2002	1,356	136	10	136		1,052	10
11	Classroom Tile	2002	500	50	10	50		383	11
12	Heat Exchanger	2002	1,106	74	15	74		553	12
13	Remodeling Project	2003	3,541	354	10	354		2,508	13
14	Remodeling Project	2003	702	70	10	70		497	14
15	4 Speed Bumps & 16 Curbs Parking Lot	2003	639	64	10	64		448	15
16	Heat Exchanger, Flame Retainer, Heat	2004	1,423	142	10	142		912	16
17	Replace Booster Tank	2004	695	99	7	99		637	17
18	New Flooring in 2 Rooms	2004	2,576	368	7	368		2,300	18
19	2 F2900 Controllers and Resin	2004	5,880	840	7	840		5,320	19
20	Wall Repairs	2004	720	103	7	103		583	20
21	Therapy Room/Spa	2004	198,856	7,954	25	7,954		44,411	21
22	Replace Heater Mixing Valves	2005	1,941	277	7	277		1,501	22
23	16 Cartons VCT / Brown Base in Breakroom	2005	850	57	15	57		298	23
24	Replace Compressor	2005	1,265	127	10	127		602	24
25	Water Heater	2006	6,376	638	10	638		2,551	25
26	HVAC Unit for B Wing	2006	7,600	760	10	760		2,660	26
27	Heat Exchanger for Unit in Lounge	2006	1,172	117	10	117		410	27
28	Bearings & Drive Shaft in Kitchen	2008	992	99	10	99		223	28
29	Rooftop HVAC Unit	2008	3,973	397	10	397		860	29
30	Control Board for Carrier Unit	2008	870	87	10	87		189	30
31	Cubicle Curtain Track	2008	864	86	10	86		179	31
32	Blower Motor for A/C Unit	2007	838	56	15	56		140	32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,540,831	$ 189,362		$ 189,362	$	$ 2,528,342	34

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

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 7/1/09 Ending: 6/30/10

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		$ 7,540,831	$ 189,362		$ 189,362	$	$ 2,528,342	1
2	Drywell	2008	12,588	629	20	629		1,046	2
3	Heat exchanger replaced	2008	1,230	82	15	82		130	3
4	Blower assembly in Heil rooftop unit	2008	938	94	10	94		188	4
5	Speakers for paging system (15)	2008	1,500	150	10	150		300	5
6	Pull cord corrider lights (5)	2008	674	67	10	67		129	6
7	Shower kit	2009	685	69	10	69		98	7
8	Door for oxygen storage room	2009	1,450	97	15	97		113	8
9	Panic bar on entrance doors	2009	954	72	10	72		72	9
10	Sprinkler at entry	2009	580	34	10	34		34	10
11	Induct air purifiers (12)	2009	3,912	228	10	228		228	11
12	Induct air purifiers (4)	2010	1,270	53	10	53		53	12
13	Shower handle w/ hose	2009	1,496	87	10	87		87	13
14	Acctuator	2010	564	24	10	24		24	14
15	Ceiling outlets & raise bedroom outlets	2010	1,359	38	15	38		38	15
16	Hot water circulating pump	2010	845	28	10	28		28	16
17	Corner guards & door frame protectors	2010	532	13	10	13		13	17
18	Hard-wired smoke detectors (27)	2010	2,052	11	15	11		11	18
19	Rounding							3	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 (lines 1 thru 33)		$ 7,573,459	$ 191,138		$ 191,138	$	$ 2,530,937	34

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

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 7/1/09 Ending: 6/30/10

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 155,810	$ 27,658	$ 27,658	$		$ 79,928	71
72	Current Year Purchases	28,286	2,473	2,473			2,473	72
73	Fully Depreciated Assets	607,252	4,452	4,452			607,252	73
74	Corporate Allocation		179	179				74
75	TOTALS	$ 791,348	$ 34,762	$ 34,762	$		$ 689,653	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	1997 Ford Club Wagon	1900	$ 3,120	$	$	$		$ 3,120	76
77	Patient Transportation	A/C for Ford Club Wagon	1998	1,040					1,040	77
78	Patient Transportation	1999 Dodge Van	1999	22,678					22,678	78
79	See Attached			28,850	1,670	1,670			23,979	79
80	TOTALS			$ 55,688	$ 1,670	$ 1,670	$		$ 50,817	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)	$ 9,104,923	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 227,570	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 227,570	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,271,407	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 7/1/09 Ending: 6/30/10

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Not Applicable
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Corporate Allocation				1,922			5
6								6
7	TOTAL				$ 1,922 **			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: $ 820 Description: See Attached
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Transportation	2005 Mercury Montego	$ 487.42	$ 5,849	17
18					18
19					19
20					20
21	TOTAL		$ 487.42	$ 5,849	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 Walter Lawson Children's Home # 0035469 Report Period Beginning: 7/1/09 Ending: 6/30/10

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.

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 7/1/09 Ending: 6/30/10

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		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

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

STATE OF ILLINOIS

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 7/1/09 Ending: 6/30/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

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

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 562	$	1
2	Cash-Patient Deposits	80,018		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 56,299)	1,231,206		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	36,842		6
7	Other Prepaid Expenses	44,687		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from Corporate	2,925,488		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,318,803	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	684,428		13
14	Buildings, at Historical Cost	7,573,458		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	847,037		16
17	Accumulated Depreciation (book methods)	(3,271,407)		17
18	Deferred Charges	309,951		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):	548,458		22
23	Other(specify): Goodwill	261,131		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 6,953,056	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 11,271,859	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 286,502	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	80,018		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	284,210		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,064		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	46,934		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued HRA			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 701,728	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	6,217,644		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	HC Investments	2,824,895		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 9,042,539	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 9,744,267	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,527,592	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 11,271,859	$	48

***(See instructions.)**

Facility Name & ID Number Walter Lawson Children's Home **#** 0035469 **Report Period Beginning:** 7/1/09 **Ending:** 6/30/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,309,337	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,309,337	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	218,255	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)**	$ 218,255	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,527,592	24 *

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

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 7/1/09 Ending: 6/30/10

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

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,639,476	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,639,476	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education	1,305,437	9
10	Other Government Grants	69,103	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	8,775	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,383,315	23
	D. Non-Operating Revenue		
24	Contributions	1,268	24
25	Interest and Other Investment Income***	(2,321)	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ (1,053)	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DMH Day Training	600,873	28
28a	Miscellaneous Income	743	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 601,616	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,623,354	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	938,951	31
32	Health Care	3,119,339	32
33	General Administration	2,056,252	33
	B. Capital Expense		
34	Ownership	933,572	34
	C. Ancillary Expense		
35	Special Cost Centers	1,015,645	35
36	Provider Participation Fee	341,340	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,405,099	40
41	**Income before Income Taxes (line 30 minus line 40)****	218,255	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 218,255	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 Walter Lawson Children's Home # 0035469 Report Period Beginning: 7/1/09 Ending: 6/30/10

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	2,086	2,291	$ 101,089	$ 44.12	1
2	Assistant Director of Nursing					2
3	Registered Nurses	18,373	20,091	562,305	27.99	3
4	Licensed Practical Nurses	21,561	23,630	617,605	26.14	4
5	CNAs & Orderlies	120,939	130,272	1,577,672	12.11	5
6	CNA Trainees					6
7	Licensed Therapist	108	113	5,640	49.91	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	1,380	1,456	12,273	8.43	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,875	2,118	41,106	19.41	13
14	Head Cook	9,734	10,596	117,419	11.08	14
15	Cook Helpers/Assistants	2,920	3,098	26,436	8.53	15
16	Dishwashers					16
17	Maintenance Workers	1,889	2,044	43,310	21.19	17
18	Housekeepers	14,106	15,295	187,641	12.27	18
19	Laundry	7,202	7,830	75,696	9.67	19
20	Administrator	2,030	2,257	144,979	64.24	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,814	5,578	182,761	32.76	24
25	Vocational Instruction					25
26	Academic Instruction	44,259	47,857	828,878	17.32	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Day Training	13,266	14,471	180,367	12.46	33
34	TOTAL (lines 1 - 33)	266,542	288,997	$ 4,705,177 *	$ 16.28	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	286	$ 11,440	1.3	35
36	Medical Director	N/A	12,500	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	N/A	1,800	10.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	595	41,650	10A.3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	Education	N/A	1,928	43.3	47
48	See Attached		21,837		48
49	TOTAL (lines 35 - 48)	881	$ 91,155		49

C. CONTRACT NURSES

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

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 7/1/09 Ending: 6/30/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Theo Brandel	Administrator	0	$ 144,979
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 144,979

B. Administrative - Other

Description	Amount
Corporate Expense	$ 201,086
TOTAL (agree to Schedule V, line 17, col. 3)	$ 201,086
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Medical Rehabilitation Centers, Inc.	Management Fees	$ 540,000
BKD, LLP	Accounting Fees	4,750
Connie Rosen	Accounting Fees	1,971
Medical Rehabilitation Centers, Inc.	Legal Fees	11,284
Duane Morris	Legal Fees	42,235
Taft, Stettinius, & Hollister	Legal Fees	159
SmithAdmunsen, LLC	Legal Fees	5,149
Stoll, Keenon, & Ogden	Legal Fees	386
DeWitt, Ross, & Stevens	Legal Fees	279
Mallor, Clendening, Grodner, & Boh	Legal Fees	127
Bradley Arant Boult Cummings	Legal Fees	315
Wessles Sherman	Legal Fees	675
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 607,330

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 105,551
Unemployment Compensation Insurance	(5,236)
FICA Taxes	360,130
Employee Health Insurance	290,307
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits- Other	6,816
Retirement	9,095
Corporate Allocation	11,901
TOTAL (agree to Schedule V, line 22, col.8)	$ 778,564

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	
(Indicate # of checks performed 33)	
Patient Background Checks	1,000
Illinois Health Care Assoc.	5,134
MES of Illinois	175
Corporate Allocation	376
Other Fees	1,820
Less: Public Relations Expense	(322)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,183

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	2,828
Seminar Expense	5,273
Corporate Allocation	160
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,261

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 7/1/09 Ending: 6/30/10

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	None		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 7/1/09 Ending: 6/30/10

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **See Schedule XIX, Section F**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line **N/A**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **341,340**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **69,103**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **Yes (Owned) No (Leased)**
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. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Reznick Group**

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

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