

Facility Name & ID Number Lawrence Community Healthcare Center

0045617 Report Period Beginning: 01/01/06 Ending: 12/31/06

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>99</u>	Skilled (SNF)	<u>99</u>	<u>36,135</u>	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	<u>99</u>	TOTALS	<u>99</u>	<u>36,135</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>15,022</u>	<u>9,873</u>	<u>3,532</u>	<u>28,427</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>15,022</u>	<u>9,873</u>	<u>3,532</u>	<u>28,427</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.67%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

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

Day Care

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 08/02/96

J. Was the facility purchased or leased after January 1, 1978?

YES Date 08/02/96 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 56 and days of care provided 3,532

Medicare Intermediary Administar Federal, Inc

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	159,750	17,772	11,121	188,643		188,643	(8,633)	180,010		1
2	Food Purchase		156,116		156,116		156,116	(267)	155,849		2
3	Housekeeping	148,999	37,369	200	186,568		186,568		186,568		3
4	Laundry	20,989	27,862	(98)	48,753		48,753		48,753		4
5	Heat and Other Utilities			56,171	56,171		56,171		56,171		5
6	Maintenance	42,299	4,405	59,087	105,791		105,791		105,791		6
7	Other (specify):*										7
8	TOTAL General Services	372,037	243,524	126,481	742,042		742,042	(8,900)	733,142		8
	B. Health Care and Programs										
9	Medical Director			2,000	2,000		2,000		2,000		9
10	Nursing and Medical Records	1,118,855	70,952	27,146	1,216,953	(245,606)	971,347	(3,960)	967,387		10
10a	Therapy			381,590	381,590		381,590		381,590		10a
11	Activities	53,597	1,810	1,519	56,926		56,926		56,926		11
12	Social Services	37,869		1,519	39,388		39,388		39,388		12
13	CNA Training										13
14	Program Transportation			135	135		135		135		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,210,321	72,762	413,909	1,696,992	(245,606)	1,451,386	(3,960)	1,447,426		16
	C. General Administration										
17	Administrative	83,650		264,248	347,898	(117,753)	230,145	(92,562)	137,583		17
18	Directors Fees										18
19	Professional Services			31,440	31,440	2,332	33,772		33,772		19
20	Dues, Fees, Subscriptions & Promotions			14,025	14,025		14,025	(295)	13,730		20
21	Clerical & General Office Expenses	43,883		76,996	120,879	88,053	208,932	(24,088)	184,844		21
22	Employee Benefits & Payroll Taxes			252,073	252,073	18,320	270,393		270,393		22
23	Inservice Training & Education			2,602	2,602		2,602		2,602		23
24	Travel and Seminar			18,627	18,627	3,521	22,148		22,148		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			73,384	73,384	300	73,684		73,684		26
27	Other (specify):*										27
28	TOTAL General Administration	127,533		733,395	860,928	(5,227)	855,701	(116,945)	738,756		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,709,891	316,286	1,273,785	3,299,962	(250,833)	3,049,129	(129,805)	2,919,324		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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			49,319	49,319	28,978	78,297		78,297			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			611	611	52,077	52,688	(4,328)	48,360			32
33	Real Estate Taxes			30,729	30,729		30,729		30,729			33
34	Rent-Facility & Grounds					(79,696)	(79,696)	(65,228)	(144,924)			34
35	Rent-Equipment & Vehicles			145,493	145,493	3,277	148,770		148,770			35
36	Other (specify):*											36
37	TOTAL Ownership			226,152	226,152	4,636	230,788	(69,556)	161,232			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			155,963	155,963	245,606	401,569		401,569			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,203	54,203		54,203		54,203			42
43	Other (specify):*					591	591	(591)				43
44	TOTAL Special Cost Centers			210,166	210,166	246,197	456,363	(591)	455,772			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,709,891	316,286	1,710,103	3,736,280		3,736,280	(199,952)	3,536,328			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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$ (3,960)	10	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(8,633)	1		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	(4,328)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(267)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(2,872)	21		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(591)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(19,966)	21		24
25	Fund Raising, Advertising and Promotional	(295)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(248)	17		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>see pg. 24</u>	(1,250)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (42,410)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(157,542)	Var	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (157,542)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (199,952)		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

SEE ACCOUNTANTS' COMPILATION REPORT

Lawrence Community Healthcare Center

ID# 0045617

Report Period Beginning: 01/01/06

Ending: 12/31/06

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Miscellaneous Income	\$ (1,250)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48	Total	(1,250)		48
49				49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lawrence Community Healthcare Center

0045617

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

	Operating Expenses	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)	
	A. General Services													
1	Dietary	(8,633)	0	0	0	0	0	0	0	0	0	0	(8,633)	1
2	Food Purchase	(267)	0	0	0	0	0	0	0	0	0	0	(267)	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	(8,900)	0	0	0	0	0	0	0	0	0	0	(8,900)	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	(3,960)	0	0	0	0	0	0	0	0	0	0	(3,960)	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	(3,960)	0	0	0	0	0	0	0	0	0	0	(3,960)	16
	C. General Administration													
17	Administrative	(248)	(92,314)	0	0	0	0	0	0	0	0	0	(92,562)	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	(295)	0	0	0	0	0	0	0	0	0	0	(295)	20
21	Clerical & General Office Expenses	(24,088)	0	0	0	0	0	0	0	0	0	0	(24,088)	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):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(24,631)	(92,314)	0	(116,945)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(37,491)	(92,314)	0	(129,805)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lawrence Community Healthcare Center# 0045617

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	D. Ownership												
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(4,328)	0	0	0	0	0	0	0	0	0	0	(4,328) 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	(65,228)	0	0	0	0	0	0	0	0	0	(65,228) 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	(4,328)	(65,228)	0	(69,556) 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):*	(591)	0	0	0	0	0	0	0	0	0	0	(591) 43
44	TOTAL Special Cost Centers	(591)	0	0	0	0	0	0	0	0	0	0	(591) 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(42,410)	(157,542)	0	(199,952) 45								

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
See pg. 29						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17 Management Fees	\$ 264,000	Rincker Healthcare	100.00%	\$ 171,686	\$ (92,314)	1
2	V	34 Facility Rental	145,493	William F. Rincker Trust		80,265	(65,228)	2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 409,493			\$ 251,951	\$ * (157,542)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lawrence Community Healthcare Center # 0045617 Report Period Beginning: 01/01/06 Ending: 12/31/06

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	William F. Rincker		Management	20.00	18,339			Wages	\$ 11,661	17-1	1
2	Jane Rincker	Accounting Suprv.	Bookkeeping	20.00	106,979	10	0.25	Wages	68,021	21-1	2
3	Angela West		Management	20.00	18,339			Wages	11,661	17-1	3
4	Deanna Gillis		Management	20.00	18,339	5	0.25	Wages	11,661	17-1	4
5	William R. Gillis	Administrator	Management	20.00	25,675	32.5	0.81	Wages	99,975	17-1	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 202,979		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lawrence Community Healthcare Center

0045617

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Rincker Healthcare Corporation
 Street Address 900 E. Corporation
 City / State / Zip Code Bridgeport, IL 62417
 Phone Number (618) 945-2091
 Fax Number (618) 945-9030

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	See attached schedule pg. 25				\$	\$		\$	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 Lawrence Community Healthcare Center # 0045617 Report Period Beginning: 01/01/06 Ending: 12/31/06

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	First Financial Bank N.A.		X	Purchase	\$8,437.77	08/02/96	\$ 1,014,000	\$ 753,781	09/15/17	6.5000	\$ 50,718	1								
2												2								
3	First Financial Bank N.A.		X	Purchase - Rincker Healthcare							1,359	3								
4												4								
5			X	Purchase - Van	\$342.68	09/14/04	18,203	10,560	09/14/09	4.9000	611	5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related				\$8,780.45		\$ 1,032,203	\$ 764,341			\$ 52,688	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 1,032,203	\$ 764,341			\$ 52,688	15								

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

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

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.)

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2005 report.		\$ 30,731	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.)		\$ 30,731	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 30,729	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.		\$ 30,729	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2001	21,942	8
	2002	23,384	9
	2003	28,693	10
	2004	30,731	11
	2005	30,729	12
	FOR BHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2005 \$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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,

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lawrence Community Healthcare Cente COUNTY Lawrence

FACILITY IDPH LICENSE NUMBER 0045617

CONTACT PERSON REGARDING THIS REPORT John Knoblett, CPA

TELEPHONE (618) 943-3344 FAX #: (618) 943-2368

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2005 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200!

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. 06-000-701-0A	Land and Building	\$ 30,729.68	\$ 30,729.68
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>30,729.68</u>	\$ <u>30,729.68</u>

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct 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 hom (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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 20C tax bill which is normally paid during 2006

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,766 B. General Construction Type: Exterior Brick Frame Brick Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>52,541</u>	<u>1996</u>	<u>\$ 20,000</u>	1
2					2
3	TOTALS	<u>52,541</u>		<u>\$ 20,000</u>	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lawrence Community Healthcare Center

0045617

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	99		1996		\$ 664,000	\$ 16,600	40	\$ 16,600	\$	\$ 174,300	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Siding		1997		5,300	133	40	133		1,259	9
10	Two four ton air conditioning units		1997		3,586	359	10	359		3,407	10
11	Fire alarm system		1998		17,000	1,133	15	1,133		10,200	11
12	Telephone system w/ call lights		1998		17,300	1,730	10	1,730		14,561	12
13	Concrete pads		1998		734	49	15	49		408	13
14	Awning at back door		1998		890	59	15	59		494	14
15	Wallpaper/painting		1998		2,444		5			2,444	15
16	Asphalt parking lot		1998		13,374	1,337	10	1,337		11,702	16
17	Landscaping / trees / shrubs		1998		2,906	291	10	291		2,494	17
18	Parking Lot		1999		1,029	103	10	103		746	18
19	Flooring / tiling		1999		12,600	1,260	10	1,260		9,975	19
20	Carpentry work		1999		3,645	243	15	243		1,904	20
21	Bathroom renovation		1999		3,570	238	15	238		1,845	21
22	Hot water system		1999		10,500	700	15	700		5,425	22
23	Hand Rails		1999		3,520	235	15	235		1,819	23
24	Wallpaper/painting		1999		3,142		5			3,142	24
25	Alarm system		1999		5,297	353	15	353		2,678	25
26	Replacement windows		2000		3,864	258	15	258		1,760	26
27	Water heater		2000		4,350	435	10	435		2,936	27
28	Flooring / tiling		2000		3,200	320	10	320		2,133	28
29	Plumbing		2000		1,719	86	20	86		566	29
30	Fire suppression system		2000		1,849	74	25	74		475	30
31	Flooring / tiling		2000		2,600	260	10	260		1,668	31
32	Flooring / tiling		2001		4,450	445	10	445		2,670	32
33	Flooring / tiling		2001		3,340	334	10	334		1,976	33
34	Flooring / tiling		2001		3,150	315	10	315		1,864	34
35	Flooring / tiling		2001		4,450	445	10	445		2,633	35
36	Flooring / tiling		2001		2,625	263	10	263		1,553	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lawrence Community Healthcare Center

0045617

Report Period Beginning:

01/01/06 Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Bi-fold doors	2001	\$ 1,665	\$ 166	10	\$ 166	\$	\$ 957	37
38	120 gal water heater	2001	2,483	248	10	248		1,283	38
39	Water heater	2002	2,961	296	10	296		1,456	39
40	Temperature control valve	2002	980	98	10	98		482	40
41	Chandeliers	2002	1,532	153	10	153		741	41
42	Windows	2002	1,900	190	10	190		808	42
43	Carpet	2003	3,378	338	10	338		1,154	43
44	Carpet	2003	1,570	157	10	157		497	44
45	Water softener	2003	2,103	210	10	210		648	45
46	Air conditioning units	2003	77,655	7,766	10	7,766		26,532	46
47	Sidewalk	2005	7,600	507	15	507		718	47
48	Storage barn	2005	3,390	226	15	226		395	48
49	Doors	2005	5,042	252	20	252		441	49
50	Painting	2005	10,455	1,046	10	1,046		1,394	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									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 929,148	\$ 39,711		\$ 39,711	\$	\$ 306,543	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lawrence Community Healthcare Center # 0045617 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	\$ 527,763	\$ 28,876	\$ 28,876	\$	5-15 yrs	\$ 470,500	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	26,928				5 yrs	26,928	73
74								74
75	TOTALS	\$ 554,691	\$ 28,876	\$ 28,876	\$		\$ 497,428	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	Transport patients	2000 Ford E-250HD Van	1999	\$ 36,009	\$	\$	\$		\$ 36,009	76
77	Transport patients	2004 Toyota Sequoia	2004	48,550	9,710	9,710		5	22,657	77
78										78
79										79
80	TOTALS			\$ 84,559	\$ 9,710	\$ 9,710	\$		\$ 58,666	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)	\$ 1,588,398	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 78,297	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 78,297	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)	\$ 862,637	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.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____
Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2007</u>	\$ _____
13.	<u>/2008</u>	\$ _____
14.	<u>/2009</u>	\$ _____

* 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 Lawrence Community Healthcare Center # 0045617 Report Period Beginning: 01/01/06 Ending: 12/31/06

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5 Units Cost					
					Units	Cost				
1	Licensed Occupational Therapist	10A-3	2219 hrs	\$ 141,743		\$	\$	2,219	\$ 141,743	1
2	Licensed Speech and Language Development Therapist	10A-3	1128 hrs	64,893				1,128	64,893	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	3399 hrs	161,352				3,399	161,352	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program			227,718			17,888		245,606	12
13	Other (specify):									13
14	TOTAL			\$ 595,706		\$	\$ 17,888	6,746	\$ 613,594	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

Facility Name & ID Number Lawrence Community Healthcare Center# 0045617Report Period Beginning: 01/01/06

Ending:

12/31/06**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/06

(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	\$ 106,828	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	781,515		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	6,229		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	25,500		8
9	Other(specify): <u>Employee Advances</u>	1,332		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 921,404	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	110,967		15
16	Equipment, at Historical Cost	635,576		16
17	Accumulated Depreciation (book methods)	(618,741)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 127,802	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,049,206	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 113,812	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	70,446		30
31	Accrued Taxes Payable (excluding real estate taxes)	248		31
32	Accrued Real Estate Taxes(Sch.IX-B)	30,730		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Insurance</u>	22,269		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 237,505	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	10,560		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Advances from Owners</u>	511,113		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 521,673	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 759,178	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 290,028	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,049,206	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 55,742	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 55,742	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	334,286	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	(100,000)	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)	\$ 234,286	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)	\$ 290,028	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lawrence Community Healthcare Center # 0045617 Report Period Beginning: 01/01/06 Ending: 12/31/06

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,758,809	1
2	Discounts and Allowances for all Levels	(1,007,286)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,751,523	3
B. Ancillary Revenue			
4	Day Care	3,960	4
5	Other Care for Outpatients		5
6	Therapy	949,453	6
7	Oxygen	107,359	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,060,772	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	8,633	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	160,095	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	18,834	19
20	Radiology and X-Ray	9,156	20
21	Other Medical Services	55,975	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 252,693	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	4,328	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,328	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	1,250	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,250	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,070,566	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	742,042	31
32	Health Care	1,696,992	32
33	General Administration	860,928	33
B. Capital Expense			
34	Ownership	226,152	34
C. Ancillary Expense			
35	Special Cost Centers	155,963	35
36	Provider Participation Fee	54,203	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,736,280	40
41	Income before Income Taxes (line 30 minus line 40)**	334,286	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 334,286	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No 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 Lawrence Community Healthcare Center

0045617

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,080	2,080	\$ 53,284	\$ 25.62	1
2	Assistant Director of Nursing	2,080	2,080	41,038	19.73	2
3	Registered Nurses	10,819	11,469	199,671	17.41	3
4	Licensed Practical Nurses	11,544	11,940	177,919	14.90	4
5	CNAs & Orderlies	70,594	73,633	630,233	8.56	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,675	1,755	16,862	9.61	9
10	Activity Assistants	4,728	4,859	36,734	7.56	10
11	Social Service Workers	3,637	3,752	37,869	10.09	11
12	Dietician					12
13	Food Service Supervisor	1,808	1,888	17,988	9.53	13
14	Head Cook	2,044	2,044	31,489	15.41	14
15	Cook Helpers/Assistants	17,174	13,625	90,348	6.63	15
16	Dishwashers	2,637	2,637	19,925	7.56	16
17	Maintenance Workers	3,096	3,218	42,299	13.14	17
18	Housekeepers	18,224	21,082	148,999	7.07	18
19	Laundry	2,737	2,918	20,989	7.19	19
20	Administrator	2,080	2,080	83,650	40.22	20
21	Assistant Administrator	1,208	1,248	22,603	18.11	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,888	2,072	21,280	10.27	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,671	1,827	16,711	9.15	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	161,724	166,207	\$ 1,709,891 *	\$ 10.29	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	166	\$ 11,121	01-03	35
36	Medical Director	48	2,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	50	3,430	39-03	39
40	Physical Therapy Consultant	180	7,676	10-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	73	1,519	11-03	44
45	Social Service Consultant	73	1,519	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	590	\$ 27,265		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lawrence Community Healthcare Center

0045617

Report Period Beginning: 01/01/06

Ending: 12/31/06

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
William R. Gillis	Administration	20	\$ 83,650	Workers' Compensation Insurance	\$ 79,357	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	21,002	Advertising: Employee Recruitment	6,811	
				FICA Taxes	137,458	Health Care Worker Background Check		
				Employee Health Insurance	32,576	(Indicate # of checks performed <u>56</u>)	896	
				Employee Meals		License Fees	306	
				Illinois Municipal Retirement Fund (IMRF)*		Dues and Subscriptions	3,727	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 83,650					
(List each licensed administrator separately.)								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Replacement Taxes			\$ 248				Out-of-State Travel	\$
Management Fees			264,000					
							In-State Travel	
							Program transportation - gas, oil, etc.	9,377
							Employee mileage reimbursements	9,250
							Lodging	3,521
							Seminar Expense	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 264,248					
(Attach a copy of any management service agreement)								
C. Professional Services				TOTAL			Entertainment Expense	
Vendor/Payee	Type		Amount				(agree to Sch. V,	
Kemper CPA Group, LLP	Accounting		\$ 17,938				line 24, col. 8)	
Duane Morris	Legal		13,152					
Stout & Holtzouser	Legal		350					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 31,440					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 54,203
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. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ 0
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (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.

SEE ACCOUNTANTS' COMPILATION REPORT

Adjustments, line 29	<u>Amount</u>	<u>Line</u>
Miscellaneous income	<u>1,250.00</u>	21
	<u><u>1,250.00</u></u>	

Page 4, line 43 detail

	Column 3	Column 5	Total
Contributions		591	<u>591</u>
			<u><u>591</u></u>

Pg 15

There are no training fees because Lawrence Community Healthcare Center only hires fully-trained employees.

SEE ACCOUNTANTS' COMPILATION REPORT.

Pg 8 - Allocation of costs of Related Party - Rincker Healthcare, Inc.

<u>Line Description</u>	<u>Amount</u>	<u>Line Ref</u>
Administrative	53,933	17
Professional Services	2,332	19
Clerical & General Office Expenses	88,053	21
Employee Benefits & Payroll Taxes	18,320	22
Travel and Seminar	3,521	24
Insurance - Prop.Liab.Malpractice	300	26
Interest	1,359	32
Rent - Equipment & Vehicles	3,277	35
Donations	591	43
Administrative	<u>171,686</u>	17
Depreciation	28,978	30
Interest	<u>50,718</u>	32
Rent - Facility Grounds	<u>79,696</u>	34
Grand Total of allocated costs	<u><u>251,382</u></u>	

SEE ACCOUNTANTS' COMPILATION REPORT.

Reconciliation of taxable income to book net income

Book Net Income	\$ 334,286
Difference book vs. tax depreciation	38,849
Disallowed Meals & Entertainment	4,625
Accrual to cash conversion	<u>(293,826)</u>
Taxable Income	<u>\$ 83,934</u>

SEE ACCOUNTANTS' COMPILATION REPORT.

Breakdown of owner salaries from other nursing homes

	<u>William Rincker</u>	<u>Angie West</u>	<u>Deanna Gillis</u>	<u>Jane Rincker</u>	<u>William Gillis</u>
Friendship Manor	6,361.00	6,361.00	6,361.00	37,103.00	8,905.00
West Grove	5,618.00	5,618.00	5,618.00	32,774.00	7,866.00
Lawrence Comm. Healthcare Center	11,661.00	11,661.00	11,661.00	68,021.00	99,975.00
Rincker Residential	<u>6,360.00</u>	<u>6,360.00</u>	<u>6,360.00</u>	<u>37,102.00</u>	<u>8,904.00</u>
	30,000.00	30,000.00	30,000.00	175,000.00	125,650.00
Salaries reported on this cost report	<u>(6,361.00)</u>	<u>(6,361.00)</u>	<u>(6,361.00)</u>	<u>(37,103.00)</u>	<u>(8,905.00)</u>
Salaries reported by other homes	<u><u>23,639.00</u></u>	<u><u>23,639.00</u></u>	<u><u>23,639.00</u></u>	<u><u>137,897.00</u></u>	<u><u>116,745.00</u></u>

SEE ACCOUNTANTS' COMPILATION REPORT.

Fixed Assets Reconciliation

	<u>Land</u>	<u>Building & Improvements</u>	<u>Equipment</u>	<u>Vehicles</u>	<u>Total</u>
Schedule XV Balance Sheet	\$ -	\$ 110,967	\$ 551,017	\$ 84,559	\$ 746,543
Schedule XI Ownership Costs	<u>20,000</u>	<u>929,148</u>	<u>554,691</u>	<u>84,559</u>	<u>1,588,398</u>
Difference	<u><u>\$ (20,000)</u></u>	<u><u>\$ (818,181)</u></u>	<u><u>\$ (3,674)</u></u>	<u><u>\$ -</u></u>	<u><u>\$ (841,855)</u></u>

On January 1, 2002, Lawrence Community Healthcare Center was incorporated. The real estate, building, and building improvements were not included. The facility is rented from a related party and the appropriate adjustments have been made on the cost report.

SEE ACCOUNTANTS' COMPILATION REPORT.

List of Related Parties (attachment to pg. 6)

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
Angela West Trust	25%	West Grove, Inc.	Lawrenceville			
Angela West Trust	25%	Rincker Healthcare Corporation	Bridgeport			
Angela West Trust	25	Friendship Manor	St. Elmo			
Mary Jane Rincker Trust	25%	West Grove, Inc.	Lawrenceville			
Mary Jane Rincker Trust	25%	Rincker Healthcare Corporation	Bridgeport			
Mary Jane Rincker Trust	25%	Friendship Manor	St. Elmo			
Deanna Gillis Trust	25%	West Grove, Inc.	Lawrenceville			
Deanna Gillis Trust	25%	Rincker Healthcare Corporation	Bridgeport			
Deanna Gillis Trust	25%	Friendship Manor	St. Elmo			
William J. Rincker Trust	25%	West Grove, Inc.	Lawrenceville			
William J. Rincker Trust	25%	Rincker Healthcare Corporation	Bridgeport			
William J. Rincker Trust	25%	Friendship Manor	St. Elmo			

SEE ACCOUNTANT'S COMPILATION REPORT.