

		FOR BHF USE					

LL1

2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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 Loves Park 61111
 Number City Zip Code

County: Winnebago

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

HFS ID Number: 31-1262572

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

Type of Ownership:

<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code <u>501 (c)(3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other	

In the event there are further questions about this report, please contact:
Name: James R. Johnson **Telephone Number:** (859) 255-0075

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/06 to 06/30/07 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.

(Signed) _____ (Date) _____

Officer or Administrator of Provider (Type or Print Name) James R. Johnson

(Title) V.P. of Finance - Medical Rehabilitation Centers, Inc.

(Signed) See Compilation Report (Date) _____

Paid Preparer (Print Name and Title) Robert A. Thomas Partner

(Firm Name & Address) Thomas Healthcare Consulting, P.C. 11988 Fishers Crossing Dr., Suite 200, Fishers, IN 46038

(Telephone) (317) 577-0101 Fax # (317) 577-3389

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walter Lawson Children's Home

0035469 Report Period Beginning: 7/1/06 Ending: 06/30/07

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2	<u>93</u>	Skilled Pediatric (SNF/PED)	<u>93</u>	<u>33,945</u>	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>93</u>	TOTALS	<u>93</u>	<u>33,945</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		Medicaid Recipient	Private Pay	Other		
8	SNF					8
9	SNF/PED	<u>28,536</u>	<u>365</u>		<u>28,901</u>	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>28,536</u>	<u>365</u>		<u>28,901</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.14%

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

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

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

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

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

YES NO

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

YES NO

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

Date started 08/15/89

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

YES Date 08/15/89 NO

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

YES NO If YES, enter number of beds certified 0 and days of care provided N/A

Medicare Intermediary Not Applicable

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/07 Fiscal Year: 06/30/07

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

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 7/1/06 Ending: 06/30/07

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	180,583	7,023	10,250	197,856	3,736	201,592	(63,964)	137,628			1
2	Food Purchase		167,674		167,674		167,674		167,674			2
3	Housekeeping	165,092	15,217		180,309		180,309		180,309			3
4	Laundry	62,270	10,721	843	73,834		73,834		73,834			4
5	Heat and Other Utilities			69,388	69,388		69,388		69,388			5
6	Maintenance	50,391	21,932	34,932	107,255		107,255	(383)	106,872			6
7	Other (specify):*											7
8	TOTAL General Services	458,336	222,567	115,413	796,316	3,736	800,052	(64,347)	735,705			8
	B. Health Care and Programs											
9	Medical Director			13,250	13,250		13,250		13,250			9
10	Nursing and Medical Records	2,348,647	151,843	10,332	2,510,822	4,540	2,515,362		2,515,362			10
10a	Therapy	56,801		40,530	97,331		97,331		97,331			10a
11	Activities	4,078	1,564	323	5,965		5,965		5,965			11
12	Social Services											12
13	CNA Training											13
14	Program Transportation		2,418		2,418		2,418		2,418			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,409,526	155,825	64,435	2,629,786	4,540	2,634,326		2,634,326			16
	C. General Administration											
17	Administrative	115,154		149,117	264,271	(142,251)	122,020	(6,866)	115,154			17
18	Directors Fees					6,621	6,621		6,621			18
19	Professional Services			452,646	452,646	52,476	505,122		505,122			19
20	Dues, Fees, Subscriptions & Promotions			11,673	11,673	241	11,914	(2,155)	9,759			20
21	Clerical & General Office Expenses	92,250	13,565	36,388	142,203	30,424	172,627	(40)	172,587			21
22	Employee Benefits & Payroll Taxes			696,328	696,328	3,885	700,213		700,213			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,511	3,511	143	3,654		3,654			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			46,703	46,703		46,703		46,703			26
27	Other (specify):* Bad Debt			(1,817)	(1,817)		(1,817)	1,817				27
28	TOTAL General Administration	207,404	13,565	1,394,549	1,615,518	(48,461)	1,567,057	(7,244)	1,559,813			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,075,266	391,957	1,574,397	5,041,620	(40,185)	5,001,435	(71,591)	4,929,844			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Walter Lawson Children's Home

#0035469

Report Period Beginning:

7/1/06

Ending:

06/30/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			136,278	136,278	30	136,308		136,308		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			439,295	439,295	40,618	479,913	(85,241)	394,672		32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			15,743	15,743	(463)	15,280	(1,195)	14,085		35
36	Other (specify):* Amortization			25,603	25,603		25,603	(15,078)	10,525		36
37	TOTAL Ownership			616,919	616,919	40,185	657,104	(101,514)	555,590		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			322,480	322,480		322,480		322,480		42
43	Other (specify):* Edu/Day Training	804,111	12,832	45,863	862,806		862,806		862,806		43
44	TOTAL Special Cost Centers	804,111	12,832	368,343	1,185,286		1,185,286		1,185,286		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,879,377	404,789	2,559,659	6,843,825		6,843,825	(173,105)	6,670,720		45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walter Lawson Children's Home

0035469

Report Period Beginning: 7/1/06

Ending: 06/30/07

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(34,595)	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	1,817	27		24
25	Fund Raising, Advertising and Promotional	(2,155)	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	(131,306)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (166,239)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(6,866)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (6,866)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (173,105)		37

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

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

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

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Walter Lawson Children's Home

ID# 0035469

Report Period Beginning: 7/1/06

Ending: 06/30/07

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			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	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Walter Lawson Children's Home

0035469

Report Period Beginning:

7/1/06

Ending:

06/30/07

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	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	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	(6,866)	0	0	0	0	0	0	0	0	0	(6,866)	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	(2,155)	0	0	0	0	0	0	0	0	0	0	(2,155)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	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):*	1,817	0	0	0	0	0	0	0	0	0	0	1,817	27
28	TOTAL General Administration	(338)	(6,866)	0	0	0	0	0	0	0	0	0	(7,204)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(338)	(6,866)	0	0	0	0	0	0	0	0	0	(7,204)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Walter Lawson Children's Home

0035469

Report Period Beginning:

7/1/06

Ending:

06/30/07

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(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	(34,595)	0	0	0	0	0	0	0	0	0	0	(34,595)	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):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(34,595)	0	0	0	0	0	0	0	0	0	0	(34,595)	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)	(34,933)	(6,866)	0	(41,799)	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
		Exceptional Care & Training Center	Sterling			
		Swann Special Care Center	Champaign			
		Vernon Manor Children's Home	Wabash, Indiana			
		Richland-Bean Blossom HCC	Ellettsville, Indiana			
		Hanover Nursing Center	Hanover, Indiana			
		Clay County Nursing Center	Brazil, Indiana			
		Randolph Nursing Home	Winchester, Indiana			

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	17 Corporate Expense	\$ 149,117	Hoosier Care, Inc.	100.00%	\$ 142,251	\$ (6,866)	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		\$ 149,117			\$ 142,251	\$ * (6,866)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 7/1/06 Ending: 06/30/07

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bruce Hutson, M.D.	Director	Board Meetings	0.00	8,439			Director Fees	\$ 1,655	18.8	1
2	Stephen Wood	Director	Board Meetings	0.00	8,439			Director Fees	1,655	18.8	2
3	John Gillmor	Director	Board Meetings	0.00	8,437			Director Fees	1,656	18.8	3
4	John Foos	Director	Board Meetings	0.00	8,438			Director Fees	1,655	18.8	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 6,621		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 Walter Lawson Children's Home

0035469

Report Period Beginning:

7/1/06

Ending: 06/30/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Revenue	41,622,539	8	\$ 22,782	\$ 0	6,825,417	\$ 3,736	1
2	10	Nursing / Medical Records	Revenue	41,622,539	8	27,688	0	6,825,417	4,540	2
3	18	Director's Fees	Revenue	41,622,539	8	40,374	0	6,825,417	6,621	3
4	19	Professional Fees	Revenue	41,622,539	8	320,007	0	6,825,417	52,476	4
5	20	Fees, Subscription & Promotion	Revenue	41,622,539	8	1,472	0	6,825,417	241	5
6	21	Clerical & General Office Exp.	Revenue	41,622,539	8	182,708	0	6,825,417	29,961	6
7	22	Emp. Benefits & Payroll Tax	Revenue	41,622,539	8	23,692	0	6,825,417	3,885	7
8	24	Travel & Seminar	Revenue	41,622,539	8	875	0	6,825,417	143	8
9	30	Depreciation	Revenue	41,622,539	8	182	0	6,825,417	30	9
10	32	Interest Expense	Revenue	41,622,539	8	247,694	0	6,825,417	40,618	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					\$ 867,474	\$		\$ 142,251	25

SEE ACCOUNTANTS' COMPILATION REPORT

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 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	City of Loves Park - 1999A		X	Purchase of Facility	Varies	7/8/99	\$ 5,500,000	\$ 5,110,000	06/01/2034	7.1250	\$ 367,503	1
2	City of Loves Park - 1999B		X	Purchase of Facility	Varies	7/8/99	250,000	200,000	06/02/2019	10.5000	21,146	2
3												3
4												4
5												5
	Working Capital											
6	Corporate Allocation										40,618	6
7												7
8												8
9	TOTAL Facility Related						\$ 5,750,000	\$ 5,310,000			\$ 429,267	9
	B. Non-Facility Related*											
10	Debt Allocation		X	Purchase of Facility	Varies	7/8/99		1,196,703	Varies	Varies	50,646	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	1,196,703			\$ 50,646	14
15	TOTALS (line 9+line14)						\$ 5,750,000	\$ 6,506,703			\$ 479,913	15

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Walter Lawson Children's Home# 0035469 Report Period Beginning: 7/1/06Ending: 06/30/07

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2006 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 2007 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:				
2002	_____	8		
2003	_____	9		
2004	_____	10		
2005	_____	11		
2006	_____	12		
			FOR BHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2006	\$		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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2006 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 _____

TELEPHONE (____) _____ FAX #: (____) _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(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. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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:

7/1/06 Ending:

06/30/07

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 22,382 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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

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

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>SNF/PED</u>	<u>217,364</u>	<u>1989</u>	<u>\$ 665,000</u>	<u>1</u>
2			<u>1997</u>	<u>19,428</u>	<u>2</u>
3	TOTALS	217,364		\$ 684,428	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walter Lawson Children's Home

0035469

Report Period Beginning:

7/1/06

Ending:

06/30/07

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	\$	\$ 1,516,365	4
5											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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walter Lawson Children's Home

0035469

Report Period Beginning:

7/1/06

Ending:

06/30/07

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	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	5	10	5		644	46
47	Vinyl Replacement Windows	1996	1,725	43	10	43		1,725	47
48	Install Water Heater	1997	6,014	351	10	351		6,014	48
49	Shower Trolley	1997	10,924	728	10	728		10,924	49
50	Stonebridge Tile-Bathing Area	1997	666	44	10	44		666	50
51	Drain, Lines, Vent Shower Trolley	1997	1,340	89	10	89		1,340	51
52	Install 175 Watt Fixture	1997	1,427	95	10	95		1,427	52
53	Replace Temperature Control Board - A/C	1997	1,021	76	10	76		1,021	53
54	Water Circulation Pump	1997	675	62	10	62		675	54
55	Re-Roof North Wing, Gravel Roof	1997	27,597	2,529	10	2,529		27,596	55
56	Parking Lot	1997	9,898	990	10	990		9,733	56
57	Fence	1997	5,680	568	10	568		5,538	57
58	Dirt & Sod	1997	1,075	108	10	108		1,039	58
59	Reinstall AC Roof Top Unit	1997	2,975	298	10	298		2,975	59
60	Security System	1997	2,362	236	10	236		2,342	60
61	Hopper Service Sink	1997	660	66	10	66		649	61
62	Education Wing Project	1997	285,914	14,296	20	14,296		138,192	62
63	Grade & Sod	1998	520	52	10	52		502	63
64	Replace Blower Motor	1998	620	62	10	62		595	64
65	Pour New Concrete	1998	945	95	10	95		898	65
66	Install Emergency Generator	1998	85,329	8,533	10	8,533		81,063	66
67	Cabinets & Countertops	1998	788	79	10	79		749	67
68	Replace Inducer Motor	1998	837	84	10	84		789	68
69	Replace Heat Exchanger, Burners & Deflection Plate	1998	1,228	123	10	123		1,146	69
70	TOTAL (lines 4 thru 69)		\$ 3,471,587	\$ 93,037		\$ 93,037	\$	\$ 1,918,330	70

SEE ACCOUNTANTS' COMPILATION REPORT

**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:

7/1/06

Ending:

06/30/07

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,471,587	\$ 93,037		\$ 93,037	\$	\$ 1,918,330	1
2	Install New Receptacle, Box & Separated Circuits	1998	1,639	164	10	164		1,530	2
3	Roof	1998	700	70	10	70		647	3
4	Install Thermaltite Window	1998	570	57	10	57		523	4
5	Blacktop New Parking Lot and Driveway	1998	9,752	975	10	975		8,777	5
6	Install New Aluminum Siding/Install New Gutter	1998	1,397	140	10	140		1,257	6
7	Replace Gas Valve, Thermostats, Circuit Board, Ignitor	1998	1,008	101	10	101		882	7
8	Install New Roof-Top Heating / Air Conditioning Unit	1999	4,340	434	10	434		3,689	8
9	Re-Tile Bathroom Floor and Walls	1999	2,080	208	10	208		1,768	9
10	New Bathroom, Install Drain, Vent, Water Lines	1999	1,780	178	10	178		1,498	10
11	Install New Sink	1999	676	68	10	68		581	11
12	Heat Exchanger	1999	912	91	10	91		760	12
13	Roof-Top Unit Replace Motor	1999	731	73	10	73		596	13
14	Tear Off and Replace Roof	1999	2,500	125	20	125		1,000	14
15	Install New Roof Shingles, Facia Boards & Vents	1999	3,727	186	20	186		1,429	15
16	Furnish and Install True 2-Door Freezer	1999	3,265	218	15	218		1,669	16
17	Install New Heat Exchanger	2000	730	49	15	49		365	17
18	Extension and Enlargement of Sewer System Pipes	2000	1,804	120	15	120		902	18
19	Installed New 50 Gallon Water Heater	2000	918	61	15	61		449	19
20	New Toshiba Strata Digital Telephone System	2000	3,264	326	10	326		2,394	20
21	New Toshiba Strata Digital Telephone System	2000	6,528	653	10	653		4,787	21
22	New Toshiba Strata Digital Telephone System	2000	1,478	148	10	148		1,084	22
23	Tear Off and Replace North Flat Roof	2000	1,147	57	20	57		411	23
24	Replace Concrete at Pavillion	2000	2,700	180	15	180		1,230	24
25	Cement Walk & Landscaping to Prevent Flooding	2000	900	60	15	60		405	25
26	Seal and Stripe Parking Lot	2000	1,600	160	10	160		1,080	26
27	Install Two RPZ Backflow Preventor	2000	2,445	163	15	163		1,114	27
28	Fire Sprinkler System Installation	2001	37,774	1,511	25	1,511		9,821	28
29	New Laundry Room Air Intake Filter	2001	623	25	25	25		156	29
30	Sprinkler System Valve	2001	2,200	88	25	88		543	30
31	Duro-Last Roof System Installation	2001	40,846	1,634	25	1,634		10,075	31
32	Trolley Shower Mattress	2001	900	90	10	90		540	32
33	New Door	2001	2,085	139	15	139		822	33
34	TOTAL (lines 1 thru 33)		\$ 3,614,606	\$ 101,589		\$ 101,589	\$	\$ 1,981,114	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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:

7/1/06

Ending:

06/30/07

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,614,606	\$ 101,589		\$ 101,589	\$	\$ 1,981,114	1
2	Booster Pump	2001	4,837	322	15	322		1,800	2
3	Cornice	2001	859	57	15	57		334	3
4	Nurse's Station	2001	6,594	440	15	440		2,528	4
5	Foyer Carpet	2001	2,341	234	10	234		1,346	5
6	Internet Wiring	2002	2,341	156	15	156		845	6
7	Install Steel Door Frame	2002	1,485	99	15	99		479	7
8	New Heat Exchanger	2002	2,818	188	15	188		908	8
9	Gutters & Downspouts	2002	900	90	10	90		435	9
10	Internal Parts Tempering	2002	1,356	136	10	136		644	10
11	Classroom Tile	2002	500	50	10	50		233	11
12	Heat Exchanger	2002	1,106	74	15	74		332	12
13	Remodeling Project	2003	3,541	354	10	354		1,446	13
14	Remodeling Project	2003	702	70	10	70		287	14
15	4 Speed Bumps & 16 Curbs Parking Lot	2003	639	64	10	64		256	15
16	Heat Exchanger, Flame Retainer, Heat	2004	1,423	142	10	142		486	16
17	Replace Booster Tank	2004	695	99	7	99		339	17
18	New Flooring in 2 Rooms	2004	2,576	368	7	368		1,196	18
19	2 F2900 Controllers and Resin	2004	5,880	840	7	840		2,800	19
20	Wall Repairs	2004	720	103	7	103		274	20
21	Therapy Room/Spa	2004	198,856	7,954	25	7,954		20,548	21
22	Replace Heater Mixing Valves	2005	1,941	277	7	277		670	22
23	16 Cartons VCT / Brown Base in Breakroom	2005	850	57	15	57		128	23
24	Replace Compressor	2005	1,265	127	10	127		221	24
25	Water Heater	2006	6,376	638	10	638		638	25
26	HVAC Unit for B Wing	2006	7,600	380	10	380		380	26
27	Heat Exchanger for Unit in Lounge	2006	1,172	59	10	59		59	27
28	Rounding		(1)	(2)		(2)		(2)	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,873,978	\$ 114,965		\$ 114,965	\$	\$ 2,020,724	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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: 7/1/06 Ending: 06/30/07

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	\$ 110,386	\$ 18,373	\$ 18,373	\$		\$ 55,657	71
72	Current Year Purchases	8,009	676	676			676	72
73	Fully Depreciated Assets	542,020	556	556			542,020	73
74	Corporate Allocation		30	30				74
75	TOTALS	\$ 660,415	\$ 19,635	\$ 19,635	\$		\$ 598,353	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	1990	\$ 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	Patient Transportation	Chevrolet Van	2001	20,500	1,708	1,708			20,500	79
80	TOTALS			\$ 47,338	\$ 1,708	\$ 1,708	\$		\$ 47,338	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)		\$ 5,266,159	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 136,308	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 136,308	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)		\$ 2,666,415	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	Construction-In-Progress	\$ 2,442,566	92
93			93
94			94
95		\$ 2,442,566	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: 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								5
6								6
7	TOTAL				\$			7

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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: \$ 8,642 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	<u>Transportation</u>	<u>2005 Mercury Montego</u>	\$ <u>553.17</u>	\$ <u>6,638</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>553.17</u>	\$ <u>6,638</u>	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.

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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walter Lawson Children's Home# 0035469Report Period Beginning: 7/1/06

Ending:

06/30/07

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/07

(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	72,137		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,536,043		3
4	Supply Inventory (priced at <u>Cost</u>)	15,818		4
5	Short-Term Investments			5
6	Prepaid Insurance	54,309		6
7	Other Prepaid Expenses	40,177		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due from Corporate</u>	1,818,546		9
	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,537,592	\$	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	3,873,978		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	707,753		16
17	Accumulated Depreciation (book methods)	(2,666,415)		17
18	Deferred Charges	348,695		18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	3,008,631		22
23	Other(specify): <u>Goodwill</u>	302,182		23
	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,259,252	\$	24
	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,796,844	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 389,701	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	72,137		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	245,328		30
	Accrued Taxes Payable (excluding real estate taxes)	4,200		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	39,628		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued HRA</u>	10,742		36
37				37
	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 761,736	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	6,506,703		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>HC Investments</u>	1,356,000		43
44				44
	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 7,862,703	\$	45
	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 8,624,439	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,172,405	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 9,796,844	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,005,266	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,005,266	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	167,140	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) Rounding	(1)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 167,139	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)	\$ 1,172,405	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walter Lawson Children's Home

0035469

Report Period Beginning: 7/1/06

Ending: 06/30/07

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	\$ 5,260,012	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,260,012	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	987,571	9
10	Other Government Grants	63,964	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	3,865	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,055,400	23
D. Non-Operating Revenue			
24	Contributions	150,000	24
25	Interest and Other Investment Income***	34,595	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 184,595	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>DMH Day Training</u>	510,918	28
28a	<u>Miscellaneous Income</u>	40	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 510,958	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,010,965	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	796,316	31
32	Health Care	2,629,786	32
33	General Administration	1,615,518	33
B. Capital Expense			
34	Ownership	616,919	34
C. Ancillary Expense			
35	Special Cost Centers	862,806	35
36	Provider Participation Fee	322,480	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,843,825	40
41	Income before Income Taxes (line 30 minus line 40)**	167,140	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 167,140	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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Walter Lawson Children's Home

0035469

Report Period Beginning:

7/1/06

Ending:

06/30/07

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	2,070	2,086	\$ 79,316	\$ 38.02	1
2	Assistant Director of Nursing					2
3	Registered Nurses	15,957	17,522	447,400	25.53	3
4	Licensed Practical Nurses	20,345	22,794	522,143	22.91	4
5	CNAs & Orderlies	109,874	119,819	1,299,788	10.85	5
6	CNA Trainees					6
7	Licensed Therapist	1,619	1,784	56,801	31.84	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	533	599	4,078	6.81	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,834	2,138	39,507	18.48	13
14	Head Cook	9,796	10,916	133,741	12.25	14
15	Cook Helpers/Assistants	767	918	7,335	7.99	15
16	Dishwashers					16
17	Maintenance Workers	1,987	2,442	50,391	20.64	17
18	Housekeepers	11,438	12,744	165,092	12.95	18
19	Laundry	5,934	6,608	62,270	9.42	19
20	Administrator	2,086	2,102	115,154	54.78	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,809	4,133	92,250	22.32	24
25	Vocational Instruction					25
26	Academic Instruction	35,145	38,087	643,220	16.89	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) <u>Day Training</u>	12,040	12,968	160,891	12.41	33
34	TOTAL (lines 1 - 33)	235,234	257,660	\$ 3,879,377 *	\$ 15.06	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	245	\$ 10,050	1.3	35
36	Medical Director	N/A	13,250	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	N/A	1,200	10.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	567	40,530	10A.3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	<u>Education</u>	132	5,125	43.3	47
48	<u>See Attached</u>		47,314		48
49	TOTAL (lines 35 - 48)	944	\$ 117,469		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 Walter Lawson Children's Home

0035469

Report Period Beginning: 7/1/06

Ending: 06/30/07

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		
Theo Brandel	Administrator	0	\$ 115,154	Workers' Compensation Insurance	\$ 112,572	IDPH License Fee	\$		
				Unemployment Compensation Insurance	4,959	Advertising: Employee Recruitment			
				FICA Taxes	292,972	Health Care Worker Background Check			
				Employee Health Insurance	266,373	(Indicate # of checks performed)			
				Employee Meals		Patient Background Checks	55 989		
				Illinois Municipal Retirement Fund (IMRF)*		Illinois Health Care Assoc.	5,561		
				Employee Benefits - Other	11,557	MES of Illinois	175		
				Retirement	7,895	CARF	1,650		
				Corporate Allocation	3,885	Corporate Allocation	241		
						Other Fees	3,298		
						Less: Public Relations Expense	(2,155)		
						Non-allowable advertising	()		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 115,154	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)			
				\$ 700,213		\$ 9,759			
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description			Amount		
Corporate Expense			\$ 149,117				Out-of-State Travel		
							\$		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 149,117	TOTAL			In-State Travel		
							2,126		
C. Professional Services									
Vendor/Payee	Type	Amount		Description	Line #	Amount	Seminar Expense		
Medical Rehabilitation Centers, Inc.	Management Fees	\$ 441,600					1,385		
Thomas Healthcare Consulting	Accounting Fees	4,300					Corporate Allocation		
Connie Rosen	Accounting Fees	2,249					143		
Sommer Barnard	Legal Fees	15					Entertainment Expense		
Duane Morris	Legal Fees	376					()		
Wessels & Pautsch	Legal Fees	2,372					(agree to Sch. V, line 24, col. 8)		
Boult, Cummings, Connors & Berry	Legal Fees	199					TOTAL		
CT Corporation	Legal Fees	60					\$ 3,654		
Medical Rehabilitation Centers, Inc.	Legal Fees	1,475							
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 452,646	TOTAL					

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Facility Name & ID Number Walter Lawson Children's Home

Report Period Beginning: 7/1/06 Ending:

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 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
1	None		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
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? 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. \$ 4,465 Line 10.2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 322,480
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. \$ 63,964
- (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? No
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Reznick Group The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT