



Facility Name & ID Number Lawrence Community Healthcare Center

# 0045617 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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 \_\_\_\_\_

	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>36,234</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>36,234</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>15,878</u>	<u>9,374</u>	<u>3,230</u>	<u>28,482</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>15,878</u>	<u>9,374</u>	<u>3,230</u>	<u>28,482</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.61%

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 08/02/1996

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

YES  Date 08/02/1996 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 3,230

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: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number Lawrence Community Healthcare Center # 0045617 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

**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
	<b>A. General Services</b>										
1	Dietary	165,923	21,274	16,170	203,367		203,367	(7,674)	195,693		1
2	Food Purchase		203,137		203,137		203,137	(331)	202,806		2
3	Housekeeping	164,157	36,349		200,506		200,506		200,506		3
4	Laundry	37,537	26,205	387	64,129		64,129		64,129		4
5	Heat and Other Utilities			98,819	98,819		98,819		98,819		5
6	Maintenance	22,411	6,085	71,466	99,962		99,962		99,962		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>390,028</b>	<b>293,050</b>	<b>186,842</b>	<b>869,920</b>		<b>869,920</b>	<b>(8,005)</b>	<b>861,915</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			1,400	1,400		1,400		1,400		9
10	Nursing and Medical Records	1,171,542	83,282	41,073	1,295,897		1,295,897	(1,500)	1,294,397		10
10a	Therapy			312,553	312,553		312,553		312,553		10a
11	Activities	61,383	979	1,589	63,951		63,951		63,951		11
12	Social Services	39,614		1,589	41,203		41,203		41,203		12
13	CNA Training										13
14	Program Transportation			1,025	1,025		1,025		1,025		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,272,539</b>	<b>84,261</b>	<b>359,229</b>	<b>1,716,029</b>		<b>1,716,029</b>	<b>(1,500)</b>	<b>1,714,529</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	84,569		264,803	349,372	(123,231)	226,141	(81,934)	144,207		17
18	Directors Fees										18
19	Professional Services			62,220	62,220	2,788	65,008		65,008		19
20	Dues, Fees, Subscriptions & Promotions			13,484	13,484		13,484	(7,244)	6,240		20
21	Clerical & General Office Expenses	48,386		122,572	170,958	94,501	265,459	(62,368)	203,091		21
22	Employee Benefits & Payroll Taxes			276,409	276,409	15,795	292,204		292,204		22
23	Inservice Training & Education			3,458	3,458		3,458		3,458		23
24	Travel and Seminar			20,387	20,387	2,761	23,148	(7,683)	15,465		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			45,409	45,409	518	45,927		45,927		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>132,955</b>		<b>808,742</b>	<b>941,697</b>	<b>(6,868)</b>	<b>934,829</b>	<b>(159,229)</b>	<b>775,600</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,795,522</b>	<b>377,311</b>	<b>1,354,813</b>	<b>3,527,646</b>	<b>(6,868)</b>	<b>3,520,778</b>	<b>(168,734)</b>	<b>3,352,044</b>		<b>29</b>

\*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 BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			28,603	28,603	26,726	55,329		55,329			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			251	251	55,792	56,043	(7,816)	48,227			32
33	Real Estate Taxes			29,357	29,357		29,357		29,357			33
34	Rent-Facility & Grounds			145,493	145,493	(82,356)	63,137	(63,137)				34
35	Rent-Equipment & Vehicles					3,869	3,869		3,869			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			203,704	203,704	4,031	207,735	(70,953)	136,782			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			167,252	167,252		167,252		167,252			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,352	54,352		54,352		54,352			42
43	Other (specify):* <b>Contributions</b>			280	280	2,837	3,117	(3,117)				43
44	<b>TOTAL Special Cost Centers</b>			221,884	221,884	2,837	224,721	(3,117)	221,604			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,795,522	377,311	1,780,401	3,953,234		3,953,234	(242,804)	3,710,430			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	BHF USE ONLY	
1	Day Care	\$ (1,500)	10	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(7,674)	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	(7,816)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(331)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(753)	21		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(7,210)	24		19
20	Contributions	(3,117)	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	(61,485)	21		24
25	Fund Raising, Advertising and Promotional	(7,244)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(803)	17		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>See Page 5A</u>	(603)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (98,536)		\$	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)	(144,268)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (144,268)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (242,804)		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY						
48		49		50		51
						52

SEE ACCOUNTANTS' COMPILATION REPORT

Lawrence Community Healthcare Center

ID# 0045617

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Miscellaneous Income	\$ (130)	21	1
2	Owner out-of-state Travel	(473)	24	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	<b>Total</b>	(603)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Lawrence Community Healthcare Center

# 0045617

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

## 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)	
	<b>A. General Services</b>													
1	Dietary	(7,674)	0	0	0	0	0	0	0	0	0	0	(7,674)	1
2	Food Purchase	(331)	0	0	0	0	0	0	0	0	0	0	(331)	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	<b>TOTAL General Services</b>	<b>(8,005)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(8,005)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(1,500)	0	0	0	0	0	0	0	0	0	0	(1,500)	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	<b>TOTAL Health Care and Programs</b>	<b>(1,500)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,500)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	(803)	(81,131)	0	0	0	0	0	0	0	0	0	(81,934)	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	(7,244)	0	0	0	0	0	0	0	0	0	0	(7,244)	20
21	Clerical & General Office Expenses	(62,368)	0	0	0	0	0	0	0	0	0	0	(62,368)	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	(7,683)	0	0	0	0	0	0	0	0	0	0	(7,683)	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	<b>TOTAL General Administration</b>	<b>(78,098)</b>	<b>(81,131)</b>	<b>0</b>	<b>(159,229)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(87,603)</b>	<b>(81,131)</b>	<b>0</b>	<b>(168,734)</b>	<b>29</b>								

## STATE OF ILLINOIS

Facility Name & ID Number Lawrence Community Healthcare Center# 0045617

Report Period Beginning:

01/01/2008 Ending:

Summary B

12/31/2008

## 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	(7,816)	0	0	0	0	0	0	0	0	0	0	(7,816) 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	(63,137)	0	0	0	0	0	0	0	0	0	(63,137) 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	<b>TOTAL Ownership</b>	<b>(7,816)</b>	<b>(63,137)</b>	<b>0</b>	<b>(70,953) 37</b>								
	<b>Ancillary Expense</b>												
	<b>E. Special Cost Centers</b>												
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):*	(3,117)	0	0	0	0	0	0	0	0	0	0	(3,117) 43
44	<b>TOTAL Special Cost Centers</b>	<b>(3,117)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(3,117) 44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(98,536)</b>	<b>(144,268)</b>	<b>0</b>	<b>(242,804) 45</b>								

**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 Page 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%	\$ 182,869	\$	(81,131)	1
2	V	34 Facility Rental	145,493	William F. Rincker Trust		82,356		(63,137)	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			\$ 265,225	\$ *	(144,268)	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: 01/01/2008 Ending: 12/31/2008

## 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 J. Rincker		Management	20.00	20,173			Wages	\$ 12,827	17-1	1
2	Jane Rincker	Accounting Suprv.	Bookkeeping	20.00	117,677	10	0.25	Wages	74,823	21-1	2
3	Angela West		Management	20.00	20,173			Wages	12,827	17-1	3
4	Deanna Gillis		Management	20.00	23,673	5	0.25	Wages	12,827	17-1	4
5	William R. Gillis	Administrator	Management	20.00	28,242	32.5	0.81	Wages	104,825	17-1	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 218,129		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: 01/01/2008

Ending: 2/31/2008

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

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	First Financial Bank NA		X	Purchase	\$8,437.77	08/02/96	\$ 1,014,000	\$ 656,457	09/15/2017	8.7500	\$ 55,630	1								
2												2								
3	First Financial Bank NA		X	Purchase - Rincker Healthcare						7.2500	162	3								
4				See Page 25								4								
5	Toyota Financial		X	Purchase - Van	\$342.68	09/14/04	18,203	3,022	09/14/2009	4.9000	251	5								
<b>Working Capital</b>																				
6												6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>				\$8,780.45		\$ 1,032,203	\$ 659,479			\$ 56,043	9								
<b>B. Non-Facility Related*</b>																				
10												10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 1,032,203	\$ 659,479			\$ 56,043	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><b>Important</b>, 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 2007 report.		\$ 29,747	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.)		\$ 29,552	2
3. Under or (over) accrual (line 2 minus line 1).		\$ (195)	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 29,552	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 29,357	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2003	28,693	8
	2004	30,731	9
	2005	30,729	10
	2006	30,731	11
	2007	29,747	12
<b>FOR BHF USE ONLY</b>			
	13	FROM R. E. TAX STATEMENT FOR 2007 \$	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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

**2007 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 (217) 351-2073 FAX #: (217) 351-3487

**A. Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(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. <u>06-000-701-0A</u>	<u>Land &amp; Building</u>	<u>\$ 29,552.46</u>	<u>\$ 29,552.46</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		<u>\$ 29,552.46</u>	<u>\$ 29,552.46</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 20C tax bill which is normally paid during 2008

**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).

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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	<b>TOTALS</b>	<u>52,541</u>		<u>\$ 20,000</u>	3

SEE ACCOUNTANTS' COMPILATION REPORT

**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	\$	\$ 207,500	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Various Fully Depreciated Assets Thru 2008				9,172					9,172	9
10	Siding			1997	5,300	132	40	132		1,523	10
11	Fire Alarm System			1998	17,000	1,133	15	1,133		12,466	11
12	Telephone System with Call Lights			1998	17,300	1,009	10	1,009		17,300	12
13	Concrete Pads			1998	734	49	15	49		506	13
14	Awning at back door			1998	890	60	15	60		614	14
15	Asphalt parking lot			1998	13,374	335	10	335		13,374	15
16	Landscaping / Trees / Shrubs			1998	2,906	121	10	121		2,906	16
17	Parking Lot			1999	1,029	103	10	103		952	17
18	Flooring/ Tiling			1999	12,600	1,260	10	1,260		12,495	18
19	Carpentry Work			1999	3,645	243	15	243		2,390	19
20	Bathroom Renovation			1999	3,570	238	15	238		2,321	20
21	Hot Water System			1999	10,500	700	15	700		6,825	21
22	Hand Rails			1999	3,520	234	15	234		2,287	22
23	Alarm System			1999	5,297	353	15	353		3,384	23
24	Replacement Windows			2000	3,864	258	15	258		2,276	24
25	Water Heater			2000	4,350	435	10	435		3,806	25
26	Flooring/ Tiling			2000	3,200	320	10	320		2,773	26
27	Plumbing			2000	1,719	86	20	86		738	27
28	Fire Suppression System			2000	1,849	74	25	74		623	28
29	Flooring/ Tiling			2000	2,600	260	10	260		2,188	29
30	Flooring/ Tiling			2001	4,450	445	10	445		3,560	30
31	Flooring/ Tiling			2001	3,340	334	10	334		2,644	31
32	Flooring/ Tiling			2001	3,150	315	10	315		2,494	32
33	Flooring/ Tiling			2001	4,450	445	10	445		3,523	33
34	Flooring/ Tiling			2001	2,625	262	10	262		2,077	34
35	Bi-fold doors			2001	1,665	167	10	167		1,291	35
36	120 gal Water Heater			2001	2,483	248	10	248		1,779	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

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	Water Heater	2002	\$ 2,961	\$ 296	10	\$ 296	\$	\$ 2,048	37
38	Temperature Control Valve	2002	980	98	10	98		678	38
39	Chandeliers	2002	1,532	153	10	153		1,047	39
40	Windows	2002	1,900	190	10	190		1,188	40
41	Carpet	2003	3,378	338	10	338		1,830	41
42	Carpet	2003	1,570	157	10	157		811	42
43	Water Softner	2003	2,103	211	10	211		1,070	43
44	Air Conditioning Units	2003	77,655	7,766	10	7,766		42,064	44
45	Sidewalk	2005	7,600	506	15	506		1,730	45
46	Storage Barn	2005	3,390	226	15	226		842	46
47	Doors	2005	5,042	252	20	252		945	47
48	Painting	2005	10,455	1,046	10	1,046		3,486	48
49	Hall Flooring	2007	1,987	199	10	199		331	49
50	Concrete Path	2007	3,045	203	15	203		321	50
51	Carpeting for Hall 4	2008	2,229	409	5	409		409	51
52	Roof Improvements	2008	18,117	1,057	10	1,057		1,057	52
53	Roof Improvements	2008	13,165	329	10	329		329	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)		\$ 967,691	\$ 39,655		\$ 39,655	\$	\$ 385,973	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: 01/01/2008 Ending: 12/31/2008

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	\$ 68,864	\$ 5,964	\$ 5,964	\$	5-15 yrs	\$ 43,542	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	494,264					494,264	73
74								74
75	TOTALS	\$ 563,128	\$ 5,964	\$ 5,964	\$		\$ 537,806	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-250 HD Van	1999	\$ 36,009	\$	\$	\$		\$ 36,009	76
77	Transport Patients	2004 Toyota Sequoia	2004	48,550	9,710	9,710		5	42,077	77
78										78
79										79
80	TOTALS			\$ 84,559	\$ 9,710	\$ 9,710	\$		\$ 78,086	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)	\$ 1,635,378	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 55,329	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 55,329	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)	\$ 1,001,865	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	<b>TOTAL</b>				\$			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	<b>TOTAL</b>		\$	\$	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>/2009</u>	\$ _____
13.	<u>/2010</u>	\$ _____
14.	<u>/2011</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.

**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)	
<b>TOTAL TRAINED</b>	

(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	Units	Cost				
1	Licensed Occupational Therapist	10a-3	hrs	\$	2,030	\$ 115,276	\$	2,030	\$ 115,276	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		1,075	56,298		1,075	56,298	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		2,580	121,681		2,580	121,681	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	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	5,685	\$ 293,255	\$	5,685	\$ 293,255	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 &amp; ID Number Lawrence Community Healthcare Center

# 0045617

Report Period Beginning: 01/01/2008

Ending:

12/31/2008

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008 (last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 5,103	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	713,325		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	3,150		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	29,500		8
9	Other(specify): <u>Employee Advances</u>	2,940		9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 754,018	\$	10
<b>B. Long-Term Assets</b>				
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	149,509		15
16	Equipment, at Historical Cost	647,688		16
17	Accumulated Depreciation (book methods)	(674,347)		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	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 122,850	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 876,868	\$	25

		1	2	
		Operating	After	
			Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 87,665	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	3,022		29
30	Accrued Salaries Payable	20,563		30
31	Accrued Taxes Payable (excluding real estate taxes)	14,465		31
32	Accrued Real Estate Taxes(Sch.IX-B)	29,552		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Accrued Insurance</u>	14,200		36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 169,467	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>Owner Advances</u>	511,113		43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 511,113	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 680,580	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 196,288	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 876,868	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 137,964	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 137,964	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	358,324	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	(300,000)	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)	\$ 58,324	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 196,288	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,028,154	1
2	Discounts and Allowances for all Levels	(565,229)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 3,462,925</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care	1,500	4
5	Other Care for Outpatients		5
6	Therapy	515,149	6
7	Oxygen	83,569	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 600,218</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
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	7,674	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	124,676	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	13,745	19
20	Radiology and X-Ray	4,441	20
21	Other Medical Services	89,933	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 240,469</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	7,816	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 7,816</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		<b>27</b>
28	<b>Miscellaneous Income</b>	<b>130</b>	<b>28</b>
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 130</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 4,311,558</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	869,920	31
32	Health Care	1,716,029	32
33	General Administration	941,697	33
<b>B. Capital Expense</b>			
34	Ownership	203,704	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	167,252	35
36	Provider Participation Fee	54,352	36
<b>D. Other Expenses (specify):</b>			
37	<b>Charitable Contributions</b>	<b>280</b>	<b>37</b>
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 3,953,234</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>358,324</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 358,324</b>	<b>43</b>

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? See Pg. 26 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:

01/01/2008

Ending:

12/31/2008

**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	2,040	2,160	\$ 57,645	\$ 28.26	1
2	Assistant Director of Nursing	2,160	2,160	45,635	21.13	2
3	Registered Nurses	11,338	11,889	193,925	17.10	3
4	Licensed Practical Nurses	16,421	17,009	241,504	14.71	4
5	CNAs & Orderlies	70,108	73,327	612,903	8.74	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,104	2,251	20,519	9.75	9
10	Activity Assistants	5,266	5,270	40,864	7.76	10
11	Social Service Workers	3,651	3,988	39,614	10.85	11
12	Dietician					12
13	Food Service Supervisor	2,088	2,160	20,770	9.95	13
14	Head Cook	2,641	2,744	21,614	8.18	14
15	Cook Helpers/Assistants	14,322	14,927	113,508	7.93	15
16	Dishwashers	1,296	1,328	10,031	7.74	16
17	Maintenance Workers	2,184	2,192	22,411	10.26	17
18	Housekeepers	20,515	21,109	164,157	8.00	18
19	Laundry	4,893	5,027	37,537	7.67	19
20	Administrator	2,160	2,160	84,569	39.15	20
21	Assistant Administrator	1,200	1,296	25,410	21.18	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,096	3,600	22,977	10.96	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	1,719	2,009	19,929	11.59	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	168,202	176,606	\$ 1,795,522 *	\$ 10.17	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	267	\$ 16,170	1-03	35
36	Medical Director	28	1,400	9-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	50	3,367	39-03	39
40	Physical Therapy Consultant	180	7,622	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	34	1,589	11-03	44
45	Social Service Consultant	34	1,589	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	593	\$ 31,737		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

**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	\$ 84,569	Workers' Compensation Insurance	\$ 81,410	IDPH License Fee	\$	
				Unemployment Compensation Insurance	24,001	Advertising: Employee Recruitment	1,839	
				FICA Taxes	148,432	Health Care Worker Background Check	1,056	
				Employee Health Insurance	38,361	(Indicate # of checks performed <u>59</u> )		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	849	
						License Fees	2,496	
						Other Advertising	7,244	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 84,569			Less: Public Relations Expense	( )	
(List each licensed administrator separately.)						Non-allowable advertising	(7,244)	
						Yellow page advertising	( )	
<b>B. Administrative - Other</b>								
Description			Amount	TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Replacement Taxes			\$ 803	\$ 292,204			\$ 6,240	
Management Fees			264,000					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 264,803					
(Attach a copy of any management service agreement)								
<b>C. Professional Services</b>				<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>			<b>G. Schedule of Travel and Seminar**</b>	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Kemper CPA Group LLP	Accounting		\$ 19,113				Out-of-State Travel	\$
Duane Morris	Legal		42,944				Administrative Travel - Airfare/gas	473
James Stout	Legal		163				In-State Travel	
							Program Transportation - Gas/oil, ect.	15,465
							Entertainment & Meals	7,210
							Seminar Expense	
							Administrative Travel	(473)
							Entertainment Expense	(7,210)
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 62,220	\$			\$ 15,465	

\* 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 FY2005	6 FY2006	7 FY2007	8 FY2008	9 FY2009	10 FY2010	11 FY2011	12 FY2012	13 FY2013
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line \_\_\_\_\_
- (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. \$ 54,352  
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**

**Page 5 Adjustments, line 29**

	<u>Amount</u>	<u>Line</u>
Miscellaneous income	130.00	21
Owner out-of-state travel	473.00	24
	<u>603.00</u>	

**Page 15**

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

SEE ACCOUNTANTS' COMPILATION REPORT.

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

<u>Line Description</u>	<u>Amount</u>	<u>Line Ref</u>
Administrative	59,637	17
Professional Services	2,788	19
Clerical & General Office Expenses	94,501	21
Employee Benefits & Payroll Taxes	15,795	22
Travel and Seminar	2,761	24
Insurance - Prop.Liab.Malpractice	518	26
Interest	162	32
Rent - Equipment & Vehicles	3,869	35
Donations	2,837	43
Administrative	<u>182,868</u>	17
Depreciation	26,726	30
Interest	55,630	32
Rent - Facility Grounds	<u>82,356</u>	34
Grand Total of allocated costs	<u><u>256,224</u></u>	

SEE ACCOUNTANTS' COMPILATION REPORT.

**Reconciliation of taxable income to book net income**

Book Net Income	\$ 358,324
Rounding Difference	(3)
Difference book vs. tax depreciation	18,040
Disallowed Meals & Entertainment	3,281
Accrual to cash conversion	<u>(112,551)</u>
Taxable Income	<u><u>\$ 267,091</u></u>

SEE ACCOUNTANTS' COMPILATION REPORT.

**Breakdown of owner salaries from other nursing homes.**

	William J. Rincker	Angie West	Deanna Gillis	Jane Rincker	William Gillis
Friendship Manor	\$ 6,996.00	\$ 6,996.00	\$ 6,996.00	\$ 40,813.00	\$ 9,795.00
West Grove	6,181.00	6,181.00	9,681.00	36,051.00	8,652.00
Lawrence Comm. Healthcare Center	12,827.00	12,827.00	12,827.00	74,823.00	104,825.00
Rincker Residential	6,996.00	6,996.00	6,996.00	40,813.00	9,795.00
	<u>33,000.00</u>	<u>33,000.00</u>	<u>36,500.00</u>	<u>192,500.00</u>	<u>133,067.00</u>
Salaries reported on this cost report	<u>12,827.00</u>	<u>12,827.00</u>	<u>12,827.00</u>	<u>74,823.00</u>	<u>104,825.00</u>
Salaries reported by other homes	<u><u>\$ 20,173.00</u></u>	<u><u>\$ 20,173.00</u></u>	<u><u>\$ 23,673.00</u></u>	<u><u>\$ 117,677.00</u></u>	<u><u>\$ 28,242.00</u></u>

SEE ACCOUNTANTS' COMPILATION REPORT.

**Fixed Assets Reconciliation**

	<u>Land</u>	<u>Building &amp; Improvements</u>	<u>Equipment</u>	<u>Vehicles</u>	<u>Total</u>
Schedule XV Balance Sheet	\$ -	\$ 149,509	\$ 563,129	\$ 84,559	\$ 797,197
Schedule XI Ownership Costs	<u>20,000</u>	<u>967,691</u>	<u>563,128</u>	<u>84,559</u>	<u>1,635,378</u>
Difference	<u>\$ (20,000)</u>	<u>\$ (818,182)</u>	<u>\$ 1</u>	<u>\$ -</u>	<u>\$ (838,181)</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 ACCOUNTANTS' COMPILATION REPORT.