

Facility Name & ID Number Walter Lawson Children's Home

0035469 Report Period Beginning: 7/1/08 Ending: 6/30/09

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	99	Skilled Pediatric (SNF/PED)	99	36,135	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF					8
9	SNF/PED	31,795	1		31,796	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,795	1		31,796	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.99%

D. How many bed-hold days during this year were paid by the Department? 721 (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 8/15/89

J. Was the facility purchased or leased after January 1, 1978?
YES Date 8/15/89 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: 06/30/09 Fiscal Year: 06/30/09

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

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 7/1/08 Ending: 6/30/09

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	196,277	22,575	11,417	230,269	11,281	241,550	(72,318)	169,232		1
2	Food Purchase		258,104		258,104		258,104		258,104		2
3	Housekeeping	187,604	16,254	452	204,310		204,310		204,310		3
4	Laundry	73,665	10,221		83,886		83,886		83,886		4
5	Heat and Other Utilities			98,127	98,127	1,089	99,216		99,216		5
6	Maintenance	45,125	15,959	48,910	109,994	1,307	111,301		111,301		6
7	Other (specify):*										7
8	TOTAL General Services	502,671	323,113	158,906	984,690	13,677	998,367	(72,318)	926,049		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	2,547,278	183,292	19,462	2,750,032	12,539	2,762,571		2,762,571		10
10a	Therapy	8,964		40,705	49,669		49,669		49,669		10a
11	Activities	24,149	1,693		25,842		25,842		25,842		11
12	Social Services										12
13	CNA Training										13
14	Program Transportation		3,555		3,555		3,555		3,555		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,580,391	188,540	72,167	2,841,098	12,539	2,853,637		2,853,637		16
	C. General Administration										
17	Administrative	125,643		202,404	328,047	(175,173)	152,874	(27,231)	125,643		17
18	Directors Fees					6,759	6,759		6,759		18
19	Professional Services			546,255	546,255	63,323	609,578		609,578		19
20	Dues, Fees, Subscriptions & Promotions			7,945	7,945	230	8,175	(527)	7,648		20
21	Clerical & General Office Expenses	112,163	12,009	188,430	312,602	36,910	349,512	(160,507)	189,005		21
22	Employee Benefits & Payroll Taxes			749,998	749,998	10,430	760,428		760,428		22
23	Inservice Training & Education										23
24	Travel and Seminar			8,036	8,036	(56)	7,980		7,980		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			52,717	52,717		52,717		52,717		26
27	Other (specify):* Bad Debt			14,006	14,006		14,006	(14,006)			27
28	TOTAL General Administration	237,806	12,009	1,769,791	2,019,606	(57,577)	1,962,029	(202,271)	1,759,758		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,320,868	523,662	2,000,864	5,845,394	(31,361)	5,814,033	(274,589)	5,539,444		29

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

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

Facility Name & ID Number

Walter Lawson Children's Home

#0035469

Report Period Beginning:

7/1/08

Ending:

6/30/09

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			226,564	226,564	115	226,679		226,679			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			698,041	698,041	30,057	728,098	(112,841)	615,257			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds					1,848	1,848		1,848			34
35	Rent-Equipment & Vehicles			14,486	14,486	(659)	13,827		13,827			35
36	Other (specify):* Amortization			49,070	49,070		49,070	(36,073)	12,997			36
37	TOTAL Ownership			988,161	988,161	31,361	1,019,522	(148,914)	870,608			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			305,563	305,563		305,563		305,563			42
43	Other (specify):* Edu/Day Training	915,202	5,948	24,355	945,505		945,505		945,505			43
44	TOTAL Special Cost Centers	915,202	5,948	329,918	1,251,068		1,251,068		1,251,068			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,236,070	529,610	3,318,943	8,084,623		8,084,623	(423,503)	7,661,120			45

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

Walter Lawson Children's Home

ID# 0035469

Report Period Beginning: 7/1/08

Ending: 6/30/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Amortization - Goodwill	\$ (13,684)	36	1
2	Non-allowable bond acquisition costs	(22,389)	36	2
3	Non-allowable interest expense	(85,140)	32	3
4		(60)	21	4
5		(72,318)	1	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(193,591)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Walter Lawson Children's Home# 0035469

Report Period Beginning:

7/1/08

Ending:

6/30/09

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(72,318)	0	0	0	0	0	0	0	0	0	0	(72,318)	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	(72,318)	0	0	0	0	0	0	0	0	0	0	(72,318)	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	(27,231)	0	0	0	0	0	0	0	0	0	(27,231)	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	(527)	0	0	0	0	0	0	0	0	0	0	(527)	20
21	Clerical & General Office Expenses	(160,507)	0	0	0	0	0	0	0	0	0	0	(160,507)	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):*	(14,006)	0	0	0	0	0	0	0	0	0	0	(14,006)	27
28	TOTAL General Administration	(175,040)	(27,231)	0	(202,271)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(247,358)	(27,231)	0	(274,589)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Walter Lawson Children's Home# 0035469

Report Period Beginning:

7/1/08

Ending:

6/30/09

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(112,841)	0	0	0	0	0	0	0	0	0	0	(112,841)	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):*	(36,073)	0	0	0	0	0	0	0	0	0	0	(36,073)	36
37	TOTAL Ownership	(148,914)	0	0	0	0	0	0	0	0	0	0	(148,914)	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(396,272)	(27,231)	0	0	0	0	0	0	0	0	0	(423,503)	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
		Swann Special Care Center	Champaign			
		Exceptional Care & Training Center	Sterling			
		Vernon Manor Children's Home	Wabash, Indiana			
		Richland-Bean Blossom HCC	Ellettsville, Indiana			
		Exceptional Living Centers of Brazil	Brazil, Indiana			
		Clay County Nursing Center	Brazil, Indiana			
		Randolph Nursing Home	Winchester, Indiana			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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	\$ 202,404	Hoosier Care, Inc.	100.00%	\$ 175,173	\$	(27,231)	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		\$ 202,404			\$ 175,173	\$ *	(27,231)	14

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

Facility Name & ID Number

Walter Lawson Children's Home

0035469

Report Period Beginning:

7/1/08

Ending:

6/30/09

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	8,724			Director Fees	\$ 1,929	18.8	1
2	Stephen Wood	Director	Board Meetings	0.00	7,276			Director Fees	1,610	18.8	2
3	John Gillmor	Director	Board Meetings	0.00	7,276			Director Fees	1,610	18.8	3
4	John Foos	Director	Board Meetings	0.00	7,276			Director Fees	1,610	18.8	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 6,759		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Walter Lawson Children's Home

0035469

Report Period Beginning:

7/1/08

Ending: 6/30/09

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

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

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

1	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	44,383,677	8	\$ 62,270	\$ 0	8,040,506	\$ 11,281	1
2	5	Heat & Other Utilities	Revenue	44,383,677	8	6,014	0	8,040,506	1,089	2
3	6	Maintenance	Revenue	44,383,677	8	5,552	0	8,040,506	1,006	3
4	10	Nursing / Medical Records	Revenue	44,383,677	8	69,216	0	8,040,506	12,539	4
5	18	Director's Fees	Revenue	44,383,677	8	37,311	0	8,040,506	6,759	5
6	19	Professional Fees	Revenue	44,383,677	8	349,543	0	8,040,506	63,323	6
7	20	Fees, Subscription & Promotion	Revenue	44,383,677	8	1,272	0	8,040,506	230	7
8	21	Clerical & General Office Exp.	Revenue	44,383,677	8	200,276	0	8,040,506	36,282	8
9	22	Emp. Benefits & Payroll Tax	Revenue	44,383,677	8	57,575	0	8,040,506	10,430	9
10	24	Travel & Seminar	Revenue	44,383,677	8	1,182	0	8,040,506	214	10
11	30	Depreciation	Revenue	44,383,677	8	635	0	8,040,506	115	11
12	32	Interest Expense	Revenue	44,383,677	8	165,913	0	8,040,506	30,057	12
13	34	Rent - Facility	Revenue	44,383,677	8	10,200	0	8,040,506	1,848	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					\$ 966,959	\$		\$ 175,173	25

Facility Name & ID Number

Walter Lawson Children's Home

0035469

Report Period Beginning:

7/1/08

Ending:

6/30/09

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										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related Long-Term																			
1	City of Loves Park - 1999A		X	Purchase of Facility	Varies	7/8/99	\$ 5,500,000	\$ 4,975,000	06/01/2034	7.1250	\$ 357,794	1							
2	City of Loves Park - 1999B		X	Purchase of Facility	Varies	7/8/99	250,000	185,000	06/02/2019	10.5000	20,125	2							
3	Hoosier Care Investments, LLC	X		Addition to Facility	\$25,493.00	3/15/07	3,000,000	2,901,463	04/15/2027	8.0000	234,982	3							
4												4							
5												5							
Working Capital																			
6	Corporate Allocation										30,057	6							
7												7							
8												8							
9	TOTAL Facility Related				\$25,493.00		\$ 8,750,000	\$ 8,061,463			\$ 642,958	9							
B. Non-Facility Related*																			
10	Debt Allocation		X	Purchase of Facility	Varies	7/8/99		1,162,075	Varies	Varies	85,140	10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$ 1,162,075			\$ 85,140	14							
15	TOTALS (line 9+line14)						\$ 8,750,000	\$ 9,223,538			\$ 728,098	15							

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

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

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

Facility Name & ID Number Walter Lawson Children's Home

0035469

Report Period Beginning:

7/1/08

Ending:

6/30/09

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (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:

	1	2	3	4	
A. Land.	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

Facility Name & ID Number Walter Lawson Children's Home

0035469

Report Period Beginning:

7/1/08

Ending:

6/30/09

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	93		1989	1971	\$ 2,917,000	\$ 63,425	10-40	\$ 63,425	\$	\$ 1,643,215	4
5	6			2008	3,659,316	91,483	40	91,483		114,354	5
6											6
7											7
8											8
	Improvement Type**										
9	Roofing		1989		1,625		5			1,625	9
10	Carpeting		1990		936		3			936	10
11	Heater / A-C		1990		17,400		5			17,400	11
12	Improvements		1991		1,563		10			1,563	12
13	Water Heater		1991		961		10			961	13
14	Door Frame Molding		1991		527		10			527	14
15	Doors		1991		738		10			738	15
16	Water Heater		1992		1,749		10			1,749	16
17	Handrails		1992		584		10			584	17
18	Roofing		1992		2,258		10			2,258	18
19	Water Line		1992		755		10			755	19
20	Smoke Dampers		1993		2,400		10			2,400	20
21	Blacktop Driveway		1993		10,130		10			10,130	21
22	Install Duct Runs		1994		750		10			750	22
23	Remodel Laundry Room		1994		3,154		10			3,154	23
24	Weather-Stripping Replacement		1994		1,849		10			1,849	24
25	Remodel Laundry Room		1994		2,063		10			2,063	25
26	A/C Roof Top Unit		1994		8,985		10			8,985	26
27	Install Sump Pump and Man Hole		1994		3,200		10			3,200	27
28	Anti-Scald Valve		1995		696		10			696	28
29	Alarm Ansul System		1995		1,253		10			1,253	29
30	Garbage Disposal		1995		1,067		10			1,067	30
31	Water Booster System Replacement		1995		6,941		10			6,941	31
32	Carpet for Offices		1995		2,432		10			2,432	32
33	Strip/Seal North Parking Lot		1995		3,382		10			3,382	33
34	Additional Parking Spaces		1995		2,375		10			2,375	34
35	Replace Gutters & Down Spouts		1995		2,150		10			2,150	35
36	Install New Windows		1995		2,588		10			2,588	36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Walter Lawson Children's Home

0035469

Report Period Beginning:

7/1/08

Ending:

6/30/09

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		10			644	46
47	Vinyl Replacement Windows	1996	1,725		10			1,725	47
48	Install Water Heater	1997	6,014		10			6,014	48
49	Shower Trolley	1997	10,924		10			10,924	49
50	Stonebridge Tile-Bathing Area	1997	666		10			666	50
51	Drain, Lines, Vent Shower Trolley	1997	1,340		10			1,340	51
52	Install 175 Watt Fixture	1997	1,427		10			1,427	52
53	Replace Temperature Control Board - A/C	1997	1,021		10			1,021	53
54	Water Circulation Pump	1997	675		10			675	54
55	Re-Roof North Wing, Gravel Roof	1997	27,597		10			27,596	55
56	Parking Lot	1997	9,898		10			9,898	56
57	Fence	1997	5,680		10			5,680	57
58	Dirt & Sod	1997	1,075		10			1,075	58
59	Reinstall AC Roof Top Unit	1997	2,975		10			2,975	59
60	Security System	1997	2,362		10			2,362	60
61	Hopper Service Sink	1997	660		10			660	61
62	Education Wing Project	1997	285,914	14,296	20	14,296		166,783	62
63	Grade & Sod	1998	520		10			520	63
64	Replace Blower Motor	1998	620		10			620	64
65	Pour New Concrete	1998	945		10			945	65
66	Install Emergency Generator	1998	85,329		10			85,329	66
67	Cabinets & Countertops	1998	788		10			788	67
68	Replace Inducer Motor	1998	837		10			837	68
69	Replace Heat Exchanger, Burners & Deflection Plate	1998	1,228		10			1,228	69
70	TOTAL (lines 4 thru 69)		\$ 7,130,903	\$ 169,204		\$ 169,204	\$	\$ 2,193,024	70

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

Facility Name & ID Number Walter Lawson Children's Home# 0035469

Report Period Beginning:

7/1/08

Ending:

6/30/09**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		\$ 7,130,903	\$ 169,204		\$ 169,204	\$	\$ 2,193,024	1
2	Install New Receptacle, Box & Separated Circuits	1998	1,639		10			1,639	2
3	Roof	1998	700		10			700	3
4	Install Thermalite Window	1998	570		10			570	4
5	Blacktop New Parking Lot and Driveway	1998	9,752		10			9,752	5
6	Install New Aluminum Siding/Install New Gutter	1998	1,397		10			1,397	6
7	Replace Gas Valve, Thermostats, Circuit Board, Ignitor	1998	1,008	25	10	25		1,008	7
8	Install New Roof-Top Heating / Air Conditioning Unit	1999	4,340	217	10	217		4,340	8
9	Re-Tile Bath tub Room Floor and Walls	1999	2,080	104	10	104		2,080	9
10	New Bath tub, Install Drain, Vent, Water Lines	1999	1,780	104	10	104		1,780	10
11	Install New Sink	1999	676	28	10	28		676	11
12	Heat Exchanger	1999	912	61	10	61		912	12
13	Roof-Top Unit Replace Motor	1999	730	61	10	61		730	13
14	Tear Off and Replace Roof	1999	2,500	125	20	125		1,250	14
15	Install New Roof Shingles, Facia Boards & Vents	1999	3,727	186	20	186		1,801	15
16	Furnish and Install True 2-Door Freezer	1999	3,265	218	15	218		2,105	16
17	Install New Heat Exchanger	2000	730	49	15	49		463	17
18	Extension and Enlargement of Sewer System Pipes	2000	1,804	120	15	120		1,142	18
19	Installed New 50 Gallon Water Heater	2000	918	61	15	61		571	19
20	New Toshiba Strata Digital Telephone System	2000	3,264	326	10	326		3,046	20
21	New Toshiba Strata Digital Telephone System	2000	6,528	653	10	653		6,093	21
22	New Toshiba Strata Digital Telephone System	2000	1,478	148	10	148		1,380	22
23	Tear Off and Replace North Flat Roof	2000	1,147	57	20	57		525	23
24	Replace Concrete at Pavillion	2000	2,700	180	15	180		1,590	24
25	Cement Walk & Landscaping to Prevent Flooding	2000	900	60	15	60		525	25
26	Seal and Stripe Parking Lot	2000	1,600	160	10	160		1,400	26
27	Install Two RPZ Backflow Preventor	2000	2,445	163	15	163		1,440	27
28	Fire Sprinkler System Installation	2001	37,774	1,511	25	1,511		12,843	28
29	New Laundry Room Air Intake Filter	2001	623	25	25	25		206	29
30	Sprinkler System Valve	2001	2,200	88	25	88		719	30
31	Duro-Last Roof System Installation	2001	40,846	1,634	25	1,634		13,343	31
32	Trolley Shower Mattress	2001	900	90	10	90		720	32
33	New Door	2001	2,085	139	15	139		1,100	33
34	TOTAL (lines 1 thru 33)		\$ 7,273,921	\$ 175,797		\$ 175,797	\$	\$ 2,270,870	34

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

Facility Name & ID Number Walter Lawson Children's Home

0035469

Report Period Beginning:

7/1/08

Ending:

6/30/09

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		\$ 7,273,921	\$ 175,797		\$ 175,797	\$	\$ 2,270,870	1
2	Booster Pump	2001	4,837	322	15	322		2,445	2
3	Cornice	2001	859	57	15	57		448	3
4	Nurse's Station	2001	6,594	440	15	440		3,407	4
5	Foyer Carpet	2001	2,341	234	10	234		1,814	5
6	Internet Wiring	2002	2,341	156	15	156		1,157	6
7	Install Steel Door Frame	2002	1,485	99	15	99		677	7
8	New Heat Exchanger	2002	2,818	188	15	188		1,284	8
9	Gutters & Downspouts	2002	900	90	10	90		615	9
10	Internal Parts Tempering	2002	1,356	136	10	136		916	10
11	Classroom Tile	2002	500	50	10	50		333	11
12	Heat Exchanger	2002	1,106	74	15	74		479	12
13	Remodeling Project	2003	3,541	354	10	354		2,154	13
14	Remodeling Project	2003	702	70	10	70		427	14
15	4 Speed Bumps & 16 Curbs Parking Lot	2003	639	64	10	64		384	15
16	Heat Exchanger, Flame Retainer, Heat	2004	1,423	142	10	142		770	16
17	Replace Booster Tank	2004	695	99	7	99		538	17
18	New Flooring in 2 Rooms	2004	2,576	368	7	368		1,932	18
19	2 F2900 Controllers and Resin	2004	5,880	840	7	840		4,480	19
20	Wall Repairs	2004	720	103	7	103		480	20
21	Therapy Room/Spa	2004	198,856	7,954	25	7,954		36,457	21
22	Replace Heater Mixing Valves	2005	1,941	277	7	277		1,224	22
23	16 Cartons VCT / Brown Base in Breakroom	2005	850	57	15	57		241	23
24	Replace Compressor	2005	1,265	127	10	127		475	24
25	Water Heater	2006	6,376	638	10	638		1,913	25
26	HVAC Unit for B Wing	2006	7,600	760	10	760		1,900	26
27	Heat Exchanger for Unit in Lounge	2006	1,172	117	10	117		293	27
28	Bearings & Drive Shaft in Kitchen	2008	992	99	10	99		124	28
29	Rooftop HVAC Unit	2008	3,973	397	10	397		463	29
30	Control Board for Carrier Unit	2008	870	87	10	87		102	30
31	Cubicle Curtain Track	2008	864	86	10	86		93	31
32	Blower Motor for A/C Unit	2007	838	56	15	56		84	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,540,831	\$ 190,338		\$ 190,338	\$	\$ 2,338,979	34

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

Facility Name & ID Number Walter Lawson Children's Home

0035469

Report Period Beginning:

7/1/08

Ending:

6/30/09

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 12C, Carried Forward		\$ 7,540,831	\$ 190,338		\$ 190,338	\$	\$ 2,338,979	1
2	Drywell	2008	12,588	417	20	417		417	2
3	Heat exchanger replaced	2008	1,230	48	15	48		48	3
4	Blower assembly in Heil rooftop unit	2008	938	94	10	94		94	4
5	Speakers for paging system (15)	2008	1,500	150	10	150		150	5
6	Pull cord corridor lights (5)	2008	674	62	10	62		62	6
7	Shower kit	2009	685	29	10	29		29	7
8	Door for oxygen storage room	2009	1,450	16	15	16		16	8
9	Rounding		(1)	2		2		3	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,559,895	\$ 191,156		\$ 191,156	\$	\$ 2,339,798	34

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

Facility Name & ID Number Walter Lawson Children's Home

0035469

Report Period Beginning:

7/1/08

Ending:

6/30/09

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	\$ 169,496	\$ 29,471	\$ 29,471	\$		\$ 82,124	71
72	Current Year Purchases	28,153	2,740	2,740			2,740	72
73	Fully Depreciated Assets	570,207	1,527	1,527			570,207	73
74	Corporate Allocation		115	115				74
75	TOTALS	\$ 767,856	\$ 33,853	\$ 33,853	\$		\$ 655,071	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	1997 Ford Club Wagon	1900	\$ 3,120	\$	\$	\$		\$ 3,120	76
77	Patient Transportation	A/C for Ford Club Wagon	1998	1,040					1,040	77
78	Patient Transportation	1999 Dodge Van	1999	22,678					22,678	78
79	See Attached			28,850	1,670	1,670			22,309	79
80	TOTALS			\$ 55,688	\$ 1,670	\$ 1,670	\$		\$ 49,147	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 9,067,867	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 226,679	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 226,679	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,044,016	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.

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? YES NO

If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Corporate Allocation				1,848			5
6								6
7	TOTAL				\$ 1,848			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: \$ 7,377 Description: See Attached

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Transportation	2005 Mercury Montego	\$ 537.49	\$ 6,450	17
18					18
19					19
20					20
21	TOTAL		\$ 537.49	\$ 6,450	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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of 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			\$		\$	\$		\$	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.

Facility Name & ID Number Walter Lawson Children's Home# 0035469Report Period Beginning: 7/1/08Ending: 6/30/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/09 (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	78,410		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>16,196</u>)	2,496,961		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	38,110		6
7	Other Prepaid Expenses	45,669		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due from Corporate</u>	1,428,747		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,088,459	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	684,428		13
14	Buildings, at Historical Cost	7,559,895		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	823,544		16
17	Accumulated Depreciation (book methods)	(3,044,016)		17
18	Deferred Charges	322,866		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):	561,697		22
23	Other(specify): <u>Goodwill</u>	274,814		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 7,183,228	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 11,271,687	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 265,912	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	78,410		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	341,746		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,900		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	47,844		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Accrued HRA</u>			36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 738,812	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	6,322,075		41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>HC Investments</u>	2,901,463		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 9,223,538	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 9,962,350	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,309,337	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 11,271,687	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,199,909	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,199,909	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	109,428	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 109,428	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)	\$ 1,309,337	24 *

* This must agree with page 17, line 47.

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	\$ 6,221,081	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,221,081	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education	1,163,374	9
10	Other Government Grants	72,318	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	47,812	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,283,504	23
D. Non-Operating Revenue			
24	Contributions	125,785	24
25	Interest and Other Investment Income***	27,701	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 153,486	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DMH Day Training	535,921	28
28a	Miscellaneous Income	60	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 535,981	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,194,052	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	984,690	31
32	Health Care	2,841,098	32
33	General Administration	2,019,606	33
B. Capital Expense			
34	Ownership	988,161	34
C. Ancillary Expense			
35	Special Cost Centers	945,505	35
36	Provider Participation Fee	305,563	36
D. Other Expenses (specify):			
37	<u>Rounding</u>	1	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,084,624	40
41	Income before Income Taxes (line 30 minus line 40)**	109,428	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 109,428	43

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

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

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

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

Facility Name & ID Number **Walter Lawson Children's Home**

0035469

Report Period Beginning:

7/1/08

Ending:

6/30/09

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	\$ 87,623	\$ 42.01	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,161	14,448	396,917	27.47	3
4	Licensed Practical Nurses	25,701	28,725	676,955	23.57	4
5	CNAs & Orderlies	106,026	116,079	1,385,783	11.94	5
6	CNA Trainees					6
7	Licensed Therapist	176	183	8,964	48.98	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,080	2,080	24,149	11.61	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,197	2,437	48,663	19.97	13
14	Head Cook	9,869	10,988	141,933	12.92	14
15	Cook Helpers/Assistants	518	613	5,681	9.27	15
16	Dishwashers					16
17	Maintenance Workers	2,105	2,241	45,125	20.14	17
18	Housekeepers	13,845	15,318	187,604	12.25	18
19	Laundry	7,408	7,864	73,665	9.37	19
20	Administrator	2,046	2,086	125,643	60.23	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,883	4,323	112,163	25.95	24
25	Vocational Instruction					25
26	Academic Instruction	42,151	45,599	741,473	16.26	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>	12,567	13,812	173,729	12.58	33
34	TOTAL (lines 1 - 33)	245,803	268,882	\$ 4,236,070 *	\$ 15.75	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	279	\$ 11,150	1.3	35
36	Medical Director	N/A	12,000	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	N/A	1,350	10.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	582	40,705	10A.3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	<u>Education</u>	N/A	1,625	43.3	47
48	<u>See Attached</u>		44,089		48
49	TOTAL (lines 35 - 48)	861	\$ 110,919		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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	
<u>Theo Brandel</u>	<u>Administrator</u>	<u>0</u>	<u>\$ 125,643</u>	<u>Workers' Compensation Insurance</u>	<u>\$ 102,823</u>	<u>IDPH License Fee</u>	<u>\$</u>	
				<u>Unemployment Compensation Insurance</u>	<u>(2,673)</u>	<u>Advertising: Employee Recruitment</u>		
				<u>FICA Taxes</u>	<u>320,853</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>314,080</u>	<u>(Indicate # of checks performed)</u>		
				<u>Employee Meals</u>		<u>Patient Background Checks</u>	<u>60</u> <u>1,032</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Illinois Health Care Assoc.</u>	<u>5,134</u>	
				<u>Employee Benefits- Other</u>	<u>6,775</u>	<u>MES of Illinois</u>	<u>175</u>	
				<u>Retirement</u>	<u>8,140</u>	<u>Corporate Allocation</u>	<u>230</u>	
				<u>Corporate Allocation</u>	<u>10,430</u>	<u>Other Fees</u>	<u>1,604</u>	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 125,643	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
(List each licensed administrator separately.)				\$ 760,428		\$ 7,648		
B. Administrative - Other			Amount	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
<u>Corporate Expense</u>			<u>\$ 202,404</u>				<u>Out-of-State Travel</u>	<u>\$</u>
							<u>In-State Travel</u>	<u>2,404</u>
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 202,404	TOTAL		\$	<u>Seminar Expense</u>	<u>5,362</u>
(Attach a copy of any management service agreement)							<u>Corporate Allocation</u>	<u>214</u>
C. Professional Services			Amount					
Vendor/Payee	Type							
<u>Medical Rehabilitation Centers, Inc.</u>	<u>Management Fees</u>	<u>\$ 524,400</u>					<u>Entertainment Expense</u> ()	
<u>Thomas Healthcare Consulting</u>	<u>Accounting Fees</u>	<u>5,977</u>					<u>(agree to Sch. V, line 24, col. 8)</u>	
<u>BKD, LLP</u>	<u>Accounting Fees</u>	<u>801</u>					TOTAL	
<u>Connie Rosen</u>	<u>Accounting Fees</u>	<u>2,433</u>					\$ 7,980	
<u>Medical Rehabilitation Centers, Inc.</u>	<u>Legal Fees</u>	<u>10,911</u>						
<u>Duane Morris</u>	<u>Legal Fees</u>	<u>104</u>						
<u>Taft, Stettinius, & Hollister</u>	<u>Legal Fees</u>	<u>270</u>						
<u>Woodward, Hobson, & Fulton</u>	<u>Legal Fees</u>	<u>63</u>						
<u>Stoll, Keenon, & Ogden</u>	<u>Legal Fees</u>	<u>308</u>						
<u>Dewitt, Ross, & Stevens</u>	<u>Legal Fees</u>	<u>302</u>						
<u>Wessels, Pautsch & Herman</u>	<u>Legal Fees</u>	<u>686</u>						
TOTAL (agree to Schedule V, line 19, column 3)			\$ 546,255					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Walter Lawson Children's Home# 0035469Report Period Beginning: 7/1/08Ending: 6/30/09**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. See Schedule XIX, Section F
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line N/A
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 305,563
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. \$ 72,318
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? Yes (Owned) No (Leased)
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Reznick Group
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.