STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT) FOR LONG-TERM CARE FACILITIES (FISCAL YEAR 2011)

I. IDPH License ID Number: 0034223

| Facility Name: | Lawrence Place |
| Address: | 715 S Washington, Lincoln 62656 |
| County: | Logan |
| Telephone Number: | (217) 732-3625 |
| Fax #: | (217) 735-4437 |
| HFS ID Number: | - |
| Date of Initial License for Current Owners: | 09/16/88 |

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/01/10 to 09/30/11 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

| Officer or Administrator of Provider | (Signed) | Laura Kelly |
| (Type or Print Name) | Director of Operations |
| (Type) | (Date) |

Preparer

| (Signed) | See Attached Independent Accountant's Report |
| See Attached Independent Accountant's Report | (Date) |

In the event there are further questions about this report, please contact:

| Name: | Ron Wilson |
| Telephone Number: | (309) 343-1550 |
| Email Address: | - |

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

SEE ACCOUNTANTS' COMPILED REPORT

HFS 3745 (N-4-99)
IL478-2471
### 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

<table>
<thead>
<tr>
<th>Level of Care</th>
<th>Beds at Beginning of Report Period</th>
<th>Licensure Level of Care</th>
<th>Beds at End of Report Period</th>
<th>Licensed Bed Days During Report Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Skilled (SNF)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Skilled Pediatric (SNF/PED)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Intermediate (ICF)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Intermediate/DD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Sheltered Care (SC)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>ICF/DD 16 or Less</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>TOTALS</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### D. How many bed-hold days during this year were paid by the Department? (Do not include bed-hold days in Section B.)
- 91

#### 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

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

#### I. On what date did you start providing long term care at this location?
- 09/16/88

#### J. Was the facility purchased or leased after January 1, 1978?
- No

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

### IV. ACCOUNTING BASIS

<table>
<thead>
<tr>
<th>Level of Care</th>
<th>Patient Days by Level of Care and Primary Source of Payment</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>SNF</td>
<td>8</td>
</tr>
<tr>
<td>9</td>
<td>SNF/PED</td>
<td>9</td>
</tr>
<tr>
<td>10</td>
<td>ICF</td>
<td>10</td>
</tr>
<tr>
<td>11</td>
<td>ICF/DD</td>
<td>11</td>
</tr>
<tr>
<td>12</td>
<td>SC</td>
<td>12</td>
</tr>
<tr>
<td>13</td>
<td>DD 16 OR LESS</td>
<td>5,749</td>
</tr>
<tr>
<td>14</td>
<td>TOTALS</td>
<td>5,749</td>
</tr>
</tbody>
</table>

#### C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)
- 98.44%

#### Tax Year:
- 09/30/11

#### Fiscal Year:
- 09/30/11

---

*All facilities other than governmental must report on the accrual basis.*
### V. COST CENTER EXPENSES

(throughout the report, please round to the nearest dollar)

<table>
<thead>
<tr>
<th>Operating Expenses</th>
<th>Costs Per General Ledger</th>
<th>Reclassified</th>
<th>Reclassified</th>
<th>Adjustments</th>
<th>Adjusted</th>
<th>FOR BHF USE ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Salary/Wage</td>
<td>Supplies</td>
<td>Other</td>
<td>Total</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>A. General Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Diet</td>
<td>38,525</td>
<td>5,832</td>
<td>1,053</td>
<td>45,410</td>
<td>45,410</td>
<td>45,410</td>
</tr>
<tr>
<td>2 Food Purchase</td>
<td>51,543</td>
<td>2,914</td>
<td>1,465</td>
<td>55,922</td>
<td>55,922</td>
<td>55,922</td>
</tr>
<tr>
<td>3 Housekeeping</td>
<td>19,922</td>
<td>4,746</td>
<td>24,668</td>
<td>24,668</td>
<td>24,668</td>
<td>24,668</td>
</tr>
<tr>
<td>4 Laundry</td>
<td>1,972</td>
<td>1,972</td>
<td>1,972</td>
<td>1,972</td>
<td>1,972</td>
<td>1,972</td>
</tr>
<tr>
<td>5 Heat and Other Utilities</td>
<td>11,889</td>
<td>11,889</td>
<td>11,889</td>
<td>11,889</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>6 Maintenance</td>
<td>9,818</td>
<td>3,531</td>
<td>20,565</td>
<td>20,565</td>
<td>20,565</td>
<td>20,565</td>
</tr>
<tr>
<td>7 Other (specify):*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 TOTAL General Services</td>
<td>68,265</td>
<td>67,624</td>
<td>156,047</td>
<td>154,582</td>
<td>8</td>
<td>154,590</td>
</tr>
<tr>
<td>B. Health Care and Programs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 Medical Director</td>
<td>4,500</td>
<td>4,500</td>
<td>4,500</td>
<td>4,500</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>10 Nursing and Medical Records</td>
<td>175,714</td>
<td>5,005</td>
<td>2,914</td>
<td>183,633</td>
<td>183,633</td>
<td>183,633</td>
</tr>
<tr>
<td>10a Therapy</td>
<td>135</td>
<td>135</td>
<td>135</td>
<td>135</td>
<td>10a</td>
<td></td>
</tr>
<tr>
<td>11 Activities</td>
<td>723</td>
<td>606</td>
<td>1,329</td>
<td>1,329</td>
<td>1,329</td>
<td>11</td>
</tr>
<tr>
<td>12 Social Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13 CNA Training</td>
<td>7,988</td>
<td>7,988</td>
<td>7,988</td>
<td>7,988</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>14 Program Transportation</td>
<td>4,522</td>
<td>4,522</td>
<td>1,651</td>
<td>6,173</td>
<td>6,173</td>
<td>14</td>
</tr>
<tr>
<td>15 Other (specify):*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16 TOTAL Health Care and Programs</td>
<td>183,702</td>
<td>5,728</td>
<td>12,677</td>
<td>202,107</td>
<td>203,758</td>
<td>203,758</td>
</tr>
<tr>
<td>C. General Administration</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17 Administrative</td>
<td>13,035</td>
<td>13,035</td>
<td>13,035</td>
<td>13,035</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>18 Directors Fees</td>
<td>817</td>
<td>817</td>
<td>817</td>
<td>817</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>19 Professional Services</td>
<td>71,652</td>
<td>71,652</td>
<td>71,652</td>
<td>71,652</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>20 Dues, Fees, Subscriptions &amp; Promotions</td>
<td>1,251</td>
<td>1,251</td>
<td>1,251</td>
<td>1,251</td>
<td>(111)</td>
<td>1,140</td>
</tr>
<tr>
<td>21 Clerical &amp; General Office Expenses</td>
<td>18,494</td>
<td>2,754</td>
<td>24,254</td>
<td>24,254</td>
<td>832</td>
<td>25,356</td>
</tr>
<tr>
<td>22 Employee Benefits &amp; Payroll Taxes</td>
<td>66,828</td>
<td>66,828</td>
<td>1,465</td>
<td>68,293</td>
<td>68,293</td>
<td>22</td>
</tr>
<tr>
<td>23 Inservice Training &amp; Education</td>
<td>3,566</td>
<td>3,566</td>
<td>3,566</td>
<td>3,566</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>24 Travel and Seminar</td>
<td>91</td>
<td>91</td>
<td>91</td>
<td>91</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>25 Other Admin. Staff Transportation</td>
<td>3,301</td>
<td>3,301</td>
<td>(1,651)</td>
<td>1,650</td>
<td>1,650</td>
<td>25</td>
</tr>
<tr>
<td>27 Other (specify):* See Att Sch VIII</td>
<td>289</td>
<td>289</td>
<td>289</td>
<td>289</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>28 TOTAL General Administration</td>
<td>31,529</td>
<td>2,754</td>
<td>160,668</td>
<td>194,951</td>
<td>194,765</td>
<td>196,018</td>
</tr>
<tr>
<td>29 TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</td>
<td>283,496</td>
<td>76,106</td>
<td>193,503</td>
<td>553,105</td>
<td>553,105</td>
<td>1,261</td>
</tr>
</tbody>
</table>

*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)

<table>
<thead>
<tr>
<th>Capital Expense</th>
<th>Cost Per General Ledger</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th>FOR BHF USE ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>D. Ownership</td>
<td>Salary/Wage</td>
<td>Supplies</td>
<td>Other</td>
<td>Total</td>
<td>Reclassification</td>
<td>Reclassified Total</td>
</tr>
<tr>
<td>30 Depreciation</td>
<td>18,669</td>
<td>18,669</td>
<td></td>
<td>18,669</td>
<td>367</td>
<td>19,036</td>
</tr>
<tr>
<td>31 Amortization of Pre-Op. &amp; Org.</td>
<td>31</td>
<td>32 Interest</td>
<td>32</td>
<td>33 Real Estate Taxes</td>
<td>33</td>
<td>34 Rent-Facility &amp; Grounds</td>
</tr>
<tr>
<td>E. Special Cost Centers</td>
<td>38 Medically Necessary Transportation</td>
<td>38</td>
<td>39 Ancillary Service Centers</td>
<td>39</td>
<td>40 Barber and Beauty Shops</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>GRAND TOTAL COST</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(sum of lines 29, 37 &amp; 44)</td>
<td>283,496</td>
<td>76,106</td>
<td>248,358</td>
<td>607,960</td>
<td>607,960</td>
</tr>
</tbody>
</table>

*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.)

<table>
<thead>
<tr>
<th>NON-ALLOWABLE EXPENSES</th>
<th>1 Amount</th>
<th>2 Reference</th>
<th>3 BHF USE ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Day Care</td>
<td>$</td>
<td></td>
<td>$ 1</td>
</tr>
<tr>
<td>2 Other Care for Outpatients</td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>3 Governmental Sponsored Special Programs</td>
<td></td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4 Non-Patient Meals</td>
<td></td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>5 Telephone, TV &amp; Radio in Resident Rooms</td>
<td></td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>6 Rented Facility Space</td>
<td></td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>7 Sale of Supplies to Non-Patients</td>
<td></td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>8 Laundry for Non-Patients</td>
<td></td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>9 Non-Straighttime Depreciation</td>
<td>(423)</td>
<td>V-30</td>
<td>9</td>
</tr>
<tr>
<td>10 Interest and Other Investment Income</td>
<td></td>
<td>V-32</td>
<td>10</td>
</tr>
<tr>
<td>11 Discounts, Allowances, Rebates &amp; Refunds</td>
<td></td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>12 Non-Working Officer's or Owner's Salary</td>
<td></td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>13 Sales Tax</td>
<td></td>
<td></td>
<td>13</td>
</tr>
<tr>
<td>14 Non-Care Related Interest</td>
<td></td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>15 Non-Care Related Owner's Transactions</td>
<td></td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>16 Personal Expenses (Including Transportation)</td>
<td></td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>17 Non-Care Related Fees</td>
<td></td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>18 Fines and Penalties</td>
<td></td>
<td></td>
<td>18</td>
</tr>
<tr>
<td>19 Entertainment</td>
<td></td>
<td></td>
<td>19</td>
</tr>
<tr>
<td>20 Contributions</td>
<td></td>
<td></td>
<td>20</td>
</tr>
<tr>
<td>21 Owner or Key-Man Insurance</td>
<td></td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>22 Special Legal Fees &amp; Legal Retainers</td>
<td></td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>23 Malpractice Insurance for Individuals</td>
<td></td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>24 Bad Debt</td>
<td>V-27</td>
<td></td>
<td>24</td>
</tr>
<tr>
<td>25 Fund Raising, Advertising and Promotional</td>
<td>(127)</td>
<td>V-20</td>
<td>25</td>
</tr>
<tr>
<td>26 Income Taxes and Illinois Personal Property Replacement Tax</td>
<td></td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>27 CNA Training for Non-Employees</td>
<td></td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>28 Yellow Page Advertising</td>
<td></td>
<td>28</td>
<td></td>
</tr>
<tr>
<td>29 Other-Attach Schedule See Att Sch IX</td>
<td>(1,814)</td>
<td></td>
<td>29</td>
</tr>
<tr>
<td>30 SUBTOTAL (A): (Sum of lines 1-29)</td>
<td>$ (2,364)</td>
<td>$</td>
<td>30</td>
</tr>
</tbody>
</table>

BHF USE ONLY

48 49 50 51 52

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

<table>
<thead>
<tr>
<th>Amount</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>31 Non-Paid Workers-Attach Schedule*</td>
<td>$</td>
</tr>
<tr>
<td>32 Donated Goods-Attach Schedule*</td>
<td>$</td>
</tr>
<tr>
<td>33 Amortization of Organization &amp; Pre-Operating Expense</td>
<td>$</td>
</tr>
<tr>
<td>34 Adjustments for Related Organization Costs (Schedule VII)</td>
<td>$</td>
</tr>
<tr>
<td>35 Other-Attach Schedule See Att Sch III</td>
<td>3,992</td>
</tr>
<tr>
<td>36 SUBTOTAL (B): (sum of lines 31-35)</td>
<td>$ 3,992</td>
</tr>
<tr>
<td>37 TOTAL ADJUSTMENTS (A) and (B)</td>
<td>$ 1,628</td>
</tr>
</tbody>
</table>

*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.)

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Amount</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>38 Medically Necessary Transport.</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>39</td>
<td></td>
<td></td>
<td>39</td>
</tr>
<tr>
<td>40</td>
<td></td>
<td>Griff and Coltec Shops</td>
<td>40</td>
</tr>
<tr>
<td>41</td>
<td></td>
<td>Barber and Beauty Shops</td>
<td>41</td>
</tr>
<tr>
<td>42</td>
<td></td>
<td>Laboratory and Radiology</td>
<td>42</td>
</tr>
<tr>
<td>43</td>
<td></td>
<td>Prescription Drugs</td>
<td>43</td>
</tr>
<tr>
<td>44</td>
<td></td>
<td></td>
<td>44</td>
</tr>
<tr>
<td>45</td>
<td></td>
<td>Other-Attach Schedule</td>
<td>45</td>
</tr>
<tr>
<td>46</td>
<td></td>
<td>Other-Attach Schedule</td>
<td>46</td>
</tr>
<tr>
<td>47</td>
<td></td>
<td>TOTAL (C): (sum of lines 38-46)</td>
<td>$</td>
</tr>
</tbody>
</table>

SEE ACCOUNTANTS' COMPILATION REPORT
<table>
<thead>
<tr>
<th>Sch. V Line</th>
<th>NON-ALLOWABLE EXPENSES</th>
<th>Amount</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td>$</td>
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</tr>
<tr>
<td>2</td>
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<td>2</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td>3</td>
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## STATE OF ILLINOIS

**Facility Name & ID Number**
Lawrence Place # 0034223

**Report Period**
Beginning: 10/01/10  
Ending: 9/30/11

---

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

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<th>PAGE 6B</th>
<th>PAGE 6C</th>
<th>PAGE 6D</th>
<th>PAGE 6E</th>
<th>PAGE 6F</th>
<th>PAGE 6G</th>
<th>PAGE 6H</th>
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### VII. RELATED PARTIES

#### A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

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<th>OTHER RELATED BUSINESS ENTITIES</th>
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#### B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. **X** YES  **NO**

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

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<th>Operating Cost of Related Organization</th>
<th>Difference: Adjustments for Related Organization Costs (7 minus 4)</th>
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* Total must agree with the amount recorded on line 34 of Schedule VI.
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<th>OTHER RELATED BUSINESS ENTITIES</th>
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</tbody>
</table>

SEE ACCOUNTANTS' COMPILATION REPORT
### 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.

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Function</th>
<th>Ownership Interest</th>
<th>Compensation Received From Other Nursing Homes*</th>
<th>Average Hours Per Work Week Devoted to this Facility and % of Total Work Week</th>
<th>Compensation Included in Costs for this Reporting Period**</th>
<th>Schedule V, Line &amp; Column Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>See Attached Schedule II &amp; III</td>
<td></td>
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<td></td>
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<td>$817</td>
<td>18-7</td>
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<td>TOTAL $817</td>
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</table>

* 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 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
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.)

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<thead>
<tr>
<th>YES</th>
<th>NO</th>
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</table>

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

<table>
<thead>
<tr>
<th>Schedule V Line Reference</th>
<th>Schedule V Item</th>
<th>Unit of Allocation</th>
<th>Total Units</th>
<th>Number of Subunits Being Allocated Among</th>
<th>Total Indirect Cost Being Allocated</th>
<th>Amount of Salary Cost Contained in Column 6</th>
<th>Facility Allocation (Col.8/Col.4)x Col.6</th>
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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.)

<table>
<thead>
<tr>
<th>Name of Lender</th>
<th>Related**</th>
<th>Purpose of Loan</th>
<th>Monthly Payment Required</th>
<th>Date of Note</th>
<th>Amount of Note</th>
<th>Maturity Date</th>
<th>Interest Rate (4 Digits)</th>
<th>Reporting Period</th>
<th>Interest Expense</th>
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<tbody>
<tr>
<td></td>
<td>YES</td>
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<td>A. Directly Facility Related</td>
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<td>B. Non-Facility Related*</td>
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<td>TOTALS (line 9+line 14)</td>
<td>YES</td>
<td>NO</td>
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16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None 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.)

** 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**: Lawrence Place # 0034223  
**Report Period Beginning**: 10/01/10  
**Ending**: 9/30/11

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

#### B. Real Estate Taxes

1. **Real Estate Tax accrual used on 2010 report.**  
   $  

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.)  
   $  

3. **Under or (over) accrual (line 2 minus line 1).**  
   $  

4. **Real Estate Tax accrual used for 2011 report.**  
   (Detail and explain your calculation of this accrual on the lines below.)  
   $  

5. **Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C.**  
   (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)  
   $  

6. **Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.**  
   **TOTAL REFUND** $ For **Tax Year.**  
   (Attach a copy of the real estate tax appeal board's decision.)  
   $  

7. **Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.**  
   $  

### Real Estate Tax History:

<table>
<thead>
<tr>
<th>Year</th>
<th>Tax Bill for Calendar Year</th>
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</thead>
<tbody>
<tr>
<td>2006</td>
<td>N/A 8</td>
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</tr>
<tr>
<td>2007</td>
<td>N/A 9</td>
<td></td>
</tr>
<tr>
<td>2008</td>
<td>N/A 10</td>
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<tr>
<td>2009</td>
<td>N/A 11</td>
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<tr>
<td>2010</td>
<td>N/A 12</td>
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</tr>
</tbody>
</table>

**FOR BHF USE ONLY**  

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
<th>Amount</th>
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<tbody>
<tr>
<td>13</td>
<td>FROM R. E. TAX STATEMENT FOR 2010</td>
<td>$ 13</td>
</tr>
<tr>
<td>14</td>
<td>PLUS APPEAL COST FROM LINE 5</td>
<td>$ 14</td>
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<tr>
<td>15</td>
<td>LESS REFUND FROM LINE 6</td>
<td>$ 15</td>
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<td>16</td>
<td>AMOUNT TO USE FOR RATE CALCULATION</td>
<td>$ 16</td>
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</table>

**This facility is owned by a non-profit organization. Real estate taxes are not assessed due to the tax exempt status of the facility. Therefore, no accrual for the real estate tax is required.**

### NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any over accrual 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
A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

<table>
<thead>
<tr>
<th>(A)</th>
<th>(B)</th>
<th>(C)</th>
<th>(D)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tax Index Number</td>
<td>Property Description</td>
<td>Total Tax</td>
<td>Tax Applicable to Nursing Home</td>
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<td>10.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>TOTALS</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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: 3,900

B. General Construction Type: Exterior Brick Frame Wood

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 X NO

If so, please complete the following:

1. Total Amount Incurred: 

2. Number of Years Over Which it is Being Amortized: 

3. Current Period Amortization: 

4. Dates Incurred: 

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

<table>
<thead>
<tr>
<th>Use</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility</td>
<td>68,328</td>
<td>1990</td>
<td>$22,692</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTALS</td>
<td>68,328</td>
<td></td>
<td>$22,692</td>
<td>3</td>
</tr>
</tbody>
</table>

SEE ACCOUNTANTS' COMPILATION REPORT
### Building and Improvement Costs-Continued

#### 4. Beds* FOR BHF USE ONLY

<table>
<thead>
<tr>
<th></th>
<th>Year Acquired</th>
<th>Year Constructed</th>
<th>Cost</th>
<th>Current Book Depreciation</th>
<th>Life in Years</th>
<th>Straight Line Depreciation</th>
<th>Adjustments</th>
<th>Accumulated Depreciation</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>1990</td>
<td>1988</td>
<td>$412,308</td>
<td>$14,167</td>
<td>30</td>
<td>$13,744</td>
<td>$(423)</td>
<td>$296,663</td>
</tr>
</tbody>
</table>

**Improvement Type**

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Year Acquired</th>
<th>Cost</th>
<th>Life</th>
<th>Depreciation</th>
<th>Adjustments</th>
<th>Accumulated Depreciation</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>Garage, Parking Lot, Sidewalks and Landscaping</td>
<td>1988</td>
<td>$10,000</td>
<td>15</td>
<td>30,000</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Shower</td>
<td>2004</td>
<td>$2,325</td>
<td>7</td>
<td>$333</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Water Heaters, Carpet/Vinyl and Shower</td>
<td>2005</td>
<td>$8,129</td>
<td>7-10 yrs</td>
<td>$905</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Vanity Sink/Drawer base/Sink/Mirror</td>
<td>2007</td>
<td>$5,189</td>
<td>15</td>
<td>$212</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Roof</td>
<td>2008</td>
<td>$11,912</td>
<td>10</td>
<td>$1,171</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Fire Alarm Panel/Air Pressure Switches</td>
<td>2009</td>
<td>$4,150</td>
<td>10</td>
<td>$416</td>
<td>14</td>
<td></td>
</tr>
</tbody>
</table>

*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.

### XI. OWNERSHIP COSTS (continued)

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

<table>
<thead>
<tr>
<th>Improvement Type**</th>
<th>Year Constructed</th>
<th>Current Book Depreciation</th>
<th>Life in Years</th>
<th>Straight Line Depreciation</th>
<th>Adjustments</th>
<th>Accumulated Depreciation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>$</td>
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<td>69</td>
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<td>69</td>
</tr>
<tr>
<td>70 TOTAL (lines 4 thru 69)</td>
<td>$471,783</td>
<td>$17,204</td>
<td>$16,781</td>
<td>(423)</td>
<td>$340,731</td>
<td></td>
</tr>
</tbody>
</table>

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.
### C. Equipment Costs-Excluding Transportation. (See instructions.)

<table>
<thead>
<tr>
<th>Category of Equipment</th>
<th>1 Cost</th>
<th>Current Book Depreciation 2</th>
<th>Straight Line Depreciation 3</th>
<th>4 Adjustments</th>
<th>Component Life 5</th>
<th>Accumulated Depreciation 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>71 Purchased in Prior Years</td>
<td>$53,264</td>
<td>$1,384</td>
<td>$1,384</td>
<td>3-12 yrs</td>
<td>$45,817</td>
<td>71</td>
</tr>
<tr>
<td>72 Current Year Purchases</td>
<td>$2,918</td>
<td>81</td>
<td>81</td>
<td>15</td>
<td>81</td>
<td>72</td>
</tr>
<tr>
<td>73 Fully Depreciated Assets</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>73</td>
</tr>
<tr>
<td>74 Indirect Costs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>790</td>
<td>74</td>
</tr>
<tr>
<td>75 TOTALS</td>
<td>$56,182</td>
<td>$2,255</td>
<td>$2,255</td>
<td></td>
<td></td>
<td>$45,898</td>
</tr>
</tbody>
</table>

### D. Vehicle Costs. (See instructions.)*

<table>
<thead>
<tr>
<th>1 Use</th>
<th>Model, Make and Year 2</th>
<th>3 Year Acquired</th>
<th>4 Cost</th>
<th>Current Book Depreciation 5</th>
<th>Straight Line Depreciation 6</th>
<th>7 Adjustments</th>
<th>Life in Years 8</th>
<th>Accumulated Depreciation 9</th>
</tr>
</thead>
<tbody>
<tr>
<td>76 Patient Care</td>
<td>2001 Ford E350 Van 2002</td>
<td>$18,301</td>
<td>$18,301</td>
<td>4 yrs</td>
<td>18,301</td>
<td>76</td>
<td></td>
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<tr>
<td>77</td>
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<td></td>
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<tr>
<td>80 TOTALS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>18,301</td>
<td>80</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### E. Summary of Care-Related Assets

<table>
<thead>
<tr>
<th>Reference</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>81 Total Historical Cost</td>
<td>$568,958</td>
</tr>
<tr>
<td>82 Current Book Depreciation</td>
<td>$19,459</td>
</tr>
<tr>
<td>83 Straight Line Depreciation</td>
<td>$19,036 **</td>
</tr>
<tr>
<td>84 Adjustments</td>
<td>$(423)</td>
</tr>
<tr>
<td>85 Accumulated Depreciation</td>
<td>$404,930</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>1 Description &amp; Year Acquired</th>
<th>2 Cost</th>
<th>Current Book Depreciation 3</th>
<th>Accumulated Depreciation 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>86</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>87</td>
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<td>87</td>
<td></td>
</tr>
<tr>
<td>88</td>
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<tr>
<td>89</td>
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<td></td>
</tr>
<tr>
<td>90</td>
<td></td>
<td>90</td>
<td></td>
</tr>
<tr>
<td>91 TOTALS</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

### G. Construction-in-Progress

<table>
<thead>
<tr>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>92</td>
<td>$</td>
</tr>
<tr>
<td>93</td>
<td>$</td>
</tr>
<tr>
<td>94</td>
<td>$</td>
</tr>
<tr>
<td>95</td>
<td>$</td>
</tr>
</tbody>
</table>

* 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: N/A facility owned

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

<table>
<thead>
<tr>
<th>1 Year Constructed</th>
<th>2 Number of Beds</th>
<th>3 Original Lease Date</th>
<th>4 Rental Amount</th>
<th>5 Total Years of Lease</th>
<th>6 Total Years Renewal Option*</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 Building:</td>
<td></td>
<td>$</td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>4 Additions</td>
<td></td>
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<td>4</td>
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<tr>
<td>5</td>
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<tr>
<td>6</td>
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<td>6</td>
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<tr>
<td>7 TOTAL</td>
<td></td>
<td>$</td>
<td></td>
<td></td>
<td>7</td>
</tr>
</tbody>
</table>

8. List separately any amortization of lease expense included on page 4, line 34.  N/A  N/A  
   This amount was calculated by dividing the total amount to be amortized by the length of the lease N/A.  

9. Option to Buy: YES NO  Terms: N/A  *

**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: $ N/A  Description:  
   (Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

<table>
<thead>
<tr>
<th>1 Use</th>
<th>2 Model Year and Make</th>
<th>3 Monthly Lease Payment</th>
<th>4 Rental Expense for this Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td></td>
<td>$</td>
<td>$ 17</td>
</tr>
<tr>
<td>18</td>
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<td></td>
<td></td>
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<tr>
<td>19</td>
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<tr>
<td>20</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21 TOTAL</td>
<td></td>
<td>$</td>
<td>$ 21</td>
</tr>
</tbody>
</table>

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. 2012  $ N/A  
   13. 2013  $ N/A  
   14. 2014  $ N/A  

12. 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.**

SEE ACCOUNTANTS' COMPILATION REPORT
Facility Name & ID Number: Lawrence Place  
# 0034223  
Report Period Beginning: 10/01/10  
Ending: 9/30/11

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?  
   - YES  
   - NO

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM
   - IN OTHER FACILITY

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM
   - IN OTHER FACILITY

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

B. EXPENSES

<table>
<thead>
<tr>
<th>ALLOCATION OF COSTS</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility</td>
<td>Drop-outs</td>
<td>Completed</td>
<td>Contract</td>
<td>Total</td>
</tr>
<tr>
<td>Community College Tuition</td>
<td></td>
<td></td>
<td></td>
<td>$7,988</td>
</tr>
<tr>
<td>2 Books and Supplies</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Classroom Wages (a)</td>
<td></td>
<td></td>
<td></td>
<td>7,988</td>
</tr>
<tr>
<td>4 Clinical Wages (b)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 In-House Trainer Wages (c)</td>
<td></td>
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</tr>
<tr>
<td>6 Transportation</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>7 Contractual Payments</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 CNA Competency Tests</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 TOTALS</td>
<td></td>
<td></td>
<td></td>
<td>7,988</td>
</tr>
<tr>
<td>10 SUM OF line 9, col. 1 and 2 (c)</td>
<td>$</td>
<td>7,988</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(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.

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

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. From this facility</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. From other facilities (f)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL TRAINED</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(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.)

<table>
<thead>
<tr>
<th>Schedule V</th>
<th>Service</th>
<th>Line &amp; Column Reference</th>
<th>Units of Service</th>
<th>Cost (other than consultant)</th>
<th>Supplies (Actual or Allocated)</th>
<th>Total Units (Column 2 + 4)</th>
<th>Total Cost (Col. 3 + 5 + 6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Licensed Occupational Therapist</td>
<td>hrs</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>Licensed Speech and Language Development Therapist</td>
<td>hrs</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>Licensed Recreational Therapist</td>
<td>hrs</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>Licensed Physical Therapist</td>
<td>hrs</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>Physician Care</td>
<td>visits</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>5</td>
</tr>
<tr>
<td>6</td>
<td>Dental Care</td>
<td>visits</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>6</td>
</tr>
<tr>
<td>7</td>
<td>Work Related Program</td>
<td>hrs</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>7</td>
</tr>
<tr>
<td>8</td>
<td>Habilitation</td>
<td>hrs</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>8</td>
</tr>
<tr>
<td>9</td>
<td>Pharmacy</td>
<td># of prescrpts</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>9</td>
</tr>
<tr>
<td>10</td>
<td>Psychological Services (Evaluation and Diagnosis/ Behavior Modification)</td>
<td>hrs</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>10</td>
</tr>
<tr>
<td>11</td>
<td>Academic Education</td>
<td>hrs</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>11</td>
</tr>
<tr>
<td>12</td>
<td>Other (specify):</td>
<td></td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>12</td>
</tr>
<tr>
<td>13</td>
<td>Other (specify):</td>
<td></td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>13</td>
</tr>
<tr>
<td>14</td>
<td>TOTAL</td>
<td></td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>14</td>
</tr>
</tbody>
</table>

**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.
### XV. BALANCE SHEET - Unrestricted Operating Fund

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

<table>
<thead>
<tr>
<th></th>
<th>1 Operating</th>
<th>2 After Consolidation*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Current Assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash on Hand and in Banks</td>
<td>$ 126</td>
<td>$ 1</td>
</tr>
<tr>
<td>Cash-Patient Deposits</td>
<td>$ 4,479</td>
<td>$ 2</td>
</tr>
<tr>
<td>Accounts &amp; Short-Term Notes Receivable-Patients (less allowance)</td>
<td>$ 92,148</td>
<td>$ 3</td>
</tr>
<tr>
<td>Supply Inventory (priced at)</td>
<td>$ 16,069</td>
<td>$ 6</td>
</tr>
<tr>
<td>Short-Term Investments</td>
<td>$ 73,119</td>
<td>$ 1</td>
</tr>
<tr>
<td>Prepaid Insurance</td>
<td>$ 10,000</td>
<td>$ 13</td>
</tr>
<tr>
<td>Other Prepaid Expenses</td>
<td>$ 74,483</td>
<td>$ 16</td>
</tr>
<tr>
<td>Accounts Receivable (owners or related parties)</td>
<td>$ 1,761,140</td>
<td>$ 9</td>
</tr>
<tr>
<td><strong>TOTAL Current Assets</strong> (sum of lines 1 thru 9)</td>
<td>$ 1,869,357</td>
<td>$ 10</td>
</tr>
<tr>
<td><strong>B. Long-Term Assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long-Term Notes Receivable</td>
<td>$ 484,475</td>
<td>$ 14</td>
</tr>
<tr>
<td>Land</td>
<td>$ 10,000</td>
<td>$ 13</td>
</tr>
<tr>
<td>Buildings, at Historical Cost</td>
<td>$ 484,475</td>
<td>$ 14</td>
</tr>
<tr>
<td>Leasehold Improvements, at Historical Cost</td>
<td>$ 54,483</td>
<td>$ 16</td>
</tr>
<tr>
<td>Equipment, at Historical Cost</td>
<td>$ (414,033)</td>
<td>$ (17)</td>
</tr>
<tr>
<td><strong>TOTAL Long-Term Assets</strong> (sum of lines 11 thru 23)</td>
<td>$ 154,925</td>
<td>$ 24</td>
</tr>
<tr>
<td><strong>TOTAL ASSETS</strong> (sum of lines 10 and 24)</td>
<td>$ 2,024,282</td>
<td>$ 25</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>1 Operating</th>
<th>2 After Consolidation*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>C. Current Liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounts Payable</td>
<td>$ 4,479</td>
<td>$ 26</td>
</tr>
<tr>
<td>Officer's Accounts Payable</td>
<td>$ 27</td>
<td></td>
</tr>
<tr>
<td>Accounts Payable-Patient Deposits</td>
<td>$ 28</td>
<td></td>
</tr>
<tr>
<td>Short-Term Notes Payable</td>
<td>$ 29</td>
<td></td>
</tr>
<tr>
<td>Accrued Salaries Payable</td>
<td>$ 11,041</td>
<td>$ 30</td>
</tr>
<tr>
<td>Accrued Taxes Payable (excluding real estate taxes)</td>
<td>$ 739</td>
<td>$ 31</td>
</tr>
<tr>
<td>Accrued Real Estate Taxes(Sch.IX-B)</td>
<td>$ 32</td>
<td></td>
</tr>
<tr>
<td>Accrued Interest Payable</td>
<td>$ 33</td>
<td></td>
</tr>
<tr>
<td>Deferred Compensation</td>
<td>$ 34</td>
<td></td>
</tr>
<tr>
<td>Federal and State Income Taxes</td>
<td>$ 35</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL Current Liabilities</strong> (sum of lines 26 thru 37)</td>
<td>$ 16,259</td>
<td>$ 38</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>1 Operating</th>
<th>2 After Consolidation*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>D. Long-Term Liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long-Term Notes Payable</td>
<td>$ 40</td>
<td></td>
</tr>
<tr>
<td>Mortgage Payable</td>
<td>$ 40</td>
<td></td>
</tr>
<tr>
<td>Bonds Payable</td>
<td>$ 41</td>
<td></td>
</tr>
<tr>
<td>Deferred Compensation</td>
<td>$ 42</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL Long-Term Liabilities</strong> (sum of lines 39 thru 44)</td>
<td>$ 16,259</td>
<td>$ 45</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>1 Operating</th>
<th>2 After Consolidation*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TOTAL LIABILITIES</strong> (sum of lines 38 and 45)</td>
<td>$ 16,259</td>
<td>$ 46</td>
</tr>
<tr>
<td><strong>TOTAL EQUITY</strong> (page 18, line 24)</td>
<td>$ 2,008,023</td>
<td>$ 47</td>
</tr>
<tr>
<td><strong>TOTAL LIABILITIES AND EQUITY</strong> (sum of lines 46 and 47)</td>
<td>$ 2,024,282</td>
<td>$ 48</td>
</tr>
</tbody>
</table>

SEE ACCOUNTANTS' COMPILATION REPORT *(See instructions.)*
### XVI. STATEMENT OF CHANGES IN EQUITY

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Amount</th>
<th>Line</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Balance at Beginning of Year, as Previously Reported</td>
<td>$1,941,066</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>Restatements (describe):</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>6</td>
<td>Balance at Beginning of Year, as Restated (sum of lines 1-5)</td>
<td>$1,941,066</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td><strong>A. Additions (deductions):</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>NET Income (Loss) (from page 19, line 43)</td>
<td>$66,957</td>
<td>7</td>
</tr>
<tr>
<td>8</td>
<td>Acquisitions of Pooled Companies</td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>9</td>
<td>Proceeds from Sale of Stock</td>
<td></td>
<td>9</td>
</tr>
<tr>
<td>10</td>
<td>Stock Options Exercised</td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>11</td>
<td>Contributions and Grants</td>
<td></td>
<td>11</td>
</tr>
<tr>
<td>12</td>
<td>Expenditures for Specific Purposes</td>
<td></td>
<td>12</td>
</tr>
<tr>
<td>13</td>
<td>Dividends Paid or Other Distributions to Owners</td>
<td>($       )</td>
<td>13</td>
</tr>
<tr>
<td>14</td>
<td>Donated Property, Plant, and Equipment</td>
<td></td>
<td>14</td>
</tr>
<tr>
<td>15</td>
<td>Other (describe)</td>
<td></td>
<td>15</td>
</tr>
<tr>
<td>16</td>
<td>Other (describe)</td>
<td></td>
<td>16</td>
</tr>
<tr>
<td>17</td>
<td><strong>TOTAL Additions (deductions) (sum of lines 7-16)</strong></td>
<td>$66,957</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td><strong>B. Transfers (Itemize):</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td></td>
<td></td>
<td>18</td>
</tr>
<tr>
<td>19</td>
<td></td>
<td></td>
<td>19</td>
</tr>
<tr>
<td>20</td>
<td></td>
<td></td>
<td>20</td>
</tr>
<tr>
<td>21</td>
<td></td>
<td></td>
<td>21</td>
</tr>
<tr>
<td>22</td>
<td></td>
<td></td>
<td>22</td>
</tr>
<tr>
<td>23</td>
<td><strong>TOTAL Transfers (sum of lines 18-22)</strong></td>
<td>$</td>
<td>23</td>
</tr>
<tr>
<td>24</td>
<td><strong>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</strong></td>
<td>$2,008,023</td>
<td>24</td>
</tr>
</tbody>
</table>

* 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.

<table>
<thead>
<tr>
<th>Revenue</th>
<th>Amount</th>
<th>Expenses</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Gross Revenue -- All Levels of Care</td>
<td>$666,888</td>
<td>1</td>
<td>Operating Expenses</td>
</tr>
<tr>
<td>2 Discounts and Allowances for all Levels</td>
<td>$( )</td>
<td>2</td>
<td>General Services</td>
</tr>
<tr>
<td>3 SUBTOTAL Inpatient Care (line 1 minus line 2)</td>
<td>$666,888</td>
<td>3</td>
<td>Health Care</td>
</tr>
<tr>
<td>4 Day Care</td>
<td>4</td>
<td>4</td>
<td>General Administration</td>
</tr>
<tr>
<td>5 Other Care for Outpatients</td>
<td>5</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>6 Therapy</td>
<td>6</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>7 Oxygen</td>
<td>7</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>8 SUBTOTAL Ancillary Revenue (lines 4 thru 7)</td>
<td>$8</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>9 Payments for Education</td>
<td>9</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>10 Other Government Grants</td>
<td>10</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>11 CNA Training Reimbursements</td>
<td>7,988</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>12 Gift and Coffee Shop</td>
<td>12</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>13 Barber and Beauty Care</td>
<td>13</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>14 Non-Patient Meals</td>
<td>14</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>15 Telephone, Television and Radio</td>
<td>15</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>16 Rental of Facility Space</td>
<td>16</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>17 Sale of Drugs</td>
<td>17</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>18 Sale of Supplies to Non-Patients</td>
<td>18</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>19 Laboratory</td>
<td>19</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>20 Radiology and X-Ray</td>
<td>20</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>21 Other Medical Services</td>
<td>21</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>22 Laundry</td>
<td>22</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>23 SUBTOTAL Other Operating Revenue (lines 9 thru 22)</td>
<td>$7,988</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>24 Contributions</td>
<td>50</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>25 Interest and Other Investment Income***</td>
<td>25</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>26 SUBTOTAL Non-Operating Revenue (lines 24 and 25)</td>
<td>$50</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>27 Settlement Income (Insurance, Legal, Etc.)</td>
<td>27</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>28</td>
<td>28</td>
<td></td>
</tr>
<tr>
<td>28a</td>
<td>28a</td>
<td>28a</td>
<td></td>
</tr>
<tr>
<td>29 SUBTOTAL Other Revenue (lines 27, 28 and 28a)</td>
<td>$29</td>
<td>29</td>
<td></td>
</tr>
<tr>
<td>30 TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</td>
<td>$674,926</td>
<td>30</td>
<td></td>
</tr>
</tbody>
</table>

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

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

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

****Provide a detailed breakdown of “Other Revenue” on an attached sheet.
### B. CONSULTANT SERVICES

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Hrs. Paid &amp; Accrued</td>
<td>Total Consultant Cost for Reporting Period</td>
<td>Schedule V Line &amp; Column Reference</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>Dietary Consultant</strong></td>
<td>$1,053</td>
<td>1-3</td>
</tr>
<tr>
<td><strong>Medical Director</strong></td>
<td>$4,500</td>
<td>9-3</td>
</tr>
<tr>
<td><strong>Medical Records Consultant</strong></td>
<td>$0</td>
<td>10-3</td>
</tr>
<tr>
<td><strong>Nurse Consultant</strong></td>
<td>$135</td>
<td>10-3</td>
</tr>
<tr>
<td><strong>Pharmacist Consultant</strong></td>
<td>$662</td>
<td>10-3</td>
</tr>
<tr>
<td><strong>Physical Therapy Consultant</strong></td>
<td>$0</td>
<td>10a-3</td>
</tr>
<tr>
<td><strong>Occupational Therapy Consultant</strong></td>
<td>$0</td>
<td>10a-3</td>
</tr>
<tr>
<td><strong>Respiratory Therapy Consultant</strong></td>
<td>$0</td>
<td>10a-3</td>
</tr>
<tr>
<td><strong>Speech Therapy Consultant</strong></td>
<td>$135</td>
<td>10a-3</td>
</tr>
<tr>
<td><strong>Activity Consultant</strong></td>
<td>$0</td>
<td>11-3</td>
</tr>
<tr>
<td><strong>Social Service Consultant</strong></td>
<td>$0</td>
<td>12-3</td>
</tr>
<tr>
<td><strong>Dental Consultant</strong></td>
<td>$1,252</td>
<td>10-3</td>
</tr>
<tr>
<td><strong>Psychological Consultant</strong></td>
<td>$1,000</td>
<td>10-3</td>
</tr>
<tr>
<td><strong>Monthly Fee</strong></td>
<td>$8,602</td>
<td>48</td>
</tr>
<tr>
<td><strong>TOTAL (lines 35 - 48)</strong></td>
<td><strong>$283,505</strong></td>
<td></td>
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</table>

### C. CONTRACT NURSES

<table>
<thead>
<tr>
<th>1</th>
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<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Hrs. Paid &amp; Accrued</td>
<td>Total Contract Wages</td>
<td>Schedule V Line &amp; Column Reference</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>Registered Nurses</strong></td>
<td>$50</td>
<td>50</td>
</tr>
<tr>
<td><strong>Licensed Practical Nurses</strong></td>
<td>$51</td>
<td>51</td>
</tr>
<tr>
<td><strong>Certified Nurse Assistants/Aides</strong></td>
<td>$52</td>
<td>52</td>
</tr>
<tr>
<td><strong>TOTAL (lines 50 - 52)</strong></td>
<td><strong>$53</strong></td>
<td></td>
</tr>
</tbody>
</table>

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* This total must agree with page 4, column 1, line 45.  
** See instructions.
<table>
<thead>
<tr>
<th>Name</th>
<th>Function</th>
<th>Ownership</th>
<th>%</th>
<th>Amount</th>
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</thead>
<tbody>
<tr>
<td>Adam Tabor</td>
<td>Administrator</td>
<td>None</td>
<td></td>
<td>$13,035</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>D. Employee Benefits and Payroll Taxes</td>
<td></td>
</tr>
<tr>
<td>Unemployment Compensation Insurance</td>
<td>$0</td>
</tr>
<tr>
<td>Workers' Compensation Insurance</td>
<td>$11,167</td>
</tr>
<tr>
<td>FICA Taxes</td>
<td>$21,264</td>
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<tr>
<td>Employee Health Insurance</td>
<td>$31,492</td>
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<tr>
<td>Employee Meals</td>
<td>$1,465</td>
</tr>
<tr>
<td>Illinois Municipal Retirement Fund (IMRF)*</td>
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</tr>
<tr>
<td>Advertising: Promotion</td>
<td>$127</td>
</tr>
<tr>
<td>IDPH License Fee</td>
<td>$</td>
</tr>
<tr>
<td>Unemployment Compensation Insurance</td>
<td>$0</td>
</tr>
<tr>
<td>Health Care Worker Background Check</td>
<td>$268</td>
</tr>
<tr>
<td>Patient Background Checks</td>
<td>$0</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</td>
<td></td>
</tr>
<tr>
<td>RFMS, Inc. Administrative Services</td>
<td>$33,990</td>
</tr>
<tr>
<td>McGladrey &amp; Pullen, LLP Accounting Services</td>
<td>$8,452</td>
</tr>
<tr>
<td>RSM McGladrey, Inc. Accounting Services</td>
<td>$547</td>
</tr>
<tr>
<td>LTC Support Services, LLC Support Services</td>
<td>$23,040</td>
</tr>
<tr>
<td>Polsinelli Shughart PC Legal Services</td>
<td>$5,623</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>Line #</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>F. Dues, Fees, Subscriptions and Promotions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advertising: Employee Recruitment</td>
<td>$15</td>
<td></td>
</tr>
<tr>
<td>IHCA Dues</td>
<td>$562</td>
<td></td>
</tr>
<tr>
<td>Other Licenses &amp; Fees</td>
<td>$9</td>
<td></td>
</tr>
<tr>
<td>Indirect costs - See Att Sch III</td>
<td>$16</td>
<td></td>
</tr>
<tr>
<td>Less: Public Relations Expense</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Non-allowable advertising</td>
<td>$127</td>
<td></td>
</tr>
<tr>
<td>Yellow page advertising</td>
<td>$</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>G. Schedule of Travel and Seminar**</td>
<td></td>
</tr>
<tr>
<td>Out-of-State Travel</td>
<td>$</td>
</tr>
<tr>
<td>In-State Travel</td>
<td>$</td>
</tr>
<tr>
<td>Staff use of personal vehicle on facility business and meals (under $250 per travel voucher)</td>
<td>$0</td>
</tr>
<tr>
<td>Seminar Expense</td>
<td>$91</td>
</tr>
<tr>
<td>Less: non-allowable out-of-state travel</td>
<td>$0</td>
</tr>
<tr>
<td>Indirect costs - See Att Sch III</td>
<td>$0</td>
</tr>
<tr>
<td>Entertainment Expense</td>
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</tbody>
</table>

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

(See instructions.)

<table>
<thead>
<tr>
<th>Improvement Type</th>
<th>Month &amp; Year Improvement Was Made</th>
<th>Total Cost</th>
<th>Useful Life</th>
<th>Amount of Expense Amortized Per Year</th>
</tr>
</thead>
<tbody>
<tr>
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<td>FY2007</td>
<td>FY2008</td>
<td>FY2009</td>
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<td>FY2013</td>
<td>FY2014</td>
<td>FY2015</td>
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<tr>
<td>19</td>
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<td>$</td>
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<td>$</td>
</tr>
<tr>
<td>20 TOTALS</td>
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<td>$</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

SEE ACCOUNTANTS' COMPILATION REPORT
### XX. GENERAL INFORMATION:

1. Are nursing employees (RN, LPN, NA) represented by a union? **No**
2. Are there any dues to nursing home associations included on the cost report? **Yes**
   - If yes, give association name and amount. See page 21 section F.
3. Did the nursing home make political contributions or payments to a political action organization? **Yes** - IHCA Dues. If yes, have these costs been properly adjusted out of the cost report? **Yes**
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? **15**
6. Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. **$1,114** Line 10
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**
9. Are you presently operating under a sublease agreement? **Yes**
10. Was this home previously operated by a related party? **No**
    - 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. **$36,186**
    - 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.

### STATE OF ILLINOIS

<table>
<thead>
<tr>
<th>#</th>
<th>Report Period Beginning: 10/01/10</th>
<th>Ending: 9/30/11</th>
</tr>
</thead>
</table>

### USE ACCOUNTANTS’ COMPILATION REPORT

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. **$1,465**
   - Has any meal income been offset against related costs? **No**
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? **None**
17. Has an audit been performed by an independent certified public accounting firm? **Yes**
    - Firm Name: McGladrey & Pullen, LLP
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.

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*Note: The document contains a table with columns and rows representing data and information as per the requirements.*