

Facility Name & ID Number Walter Lawson Children's Home

0035469 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		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 3 4 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		Medicaid Recipient	Private Pay	Other		
8	SNF					8
9	SNF/PED	34,588	30		34,618	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	34,588	30		34,618	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.80%

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

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

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

None

F. Does the facility maintain a daily midnight census?

Yes

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

YES NO

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

YES NO

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

Date started 08/15/1989

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

YES Date 08/15/1989 NO

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

YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary Non applicable

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 06/30/2011 Fiscal Year: 06/30/2011

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

Facility Name & ID Number

Walter Lawson Children's Home

0035469

Report Period Beginning:

07/01/2010

Ending:

06/30/2011

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	176,027	7,683	11,964	195,674	20,718	216,392		216,392		1
2	Food Purchase		257,923		257,923		257,923		257,923		2
3	Housekeeping	176,725	22,809	54	199,588		199,588		199,588		3
4	Laundry	81,590	3,211	575	85,376		85,376		85,376		4
5	Heat and Other Utilities			86,544	86,544	904	87,448		87,448		5
6	Maintenance	44,627	14,054	36,115	94,796	1,141	95,937		95,937		6
7	Other (specify):*										7
8	TOTAL General Services	478,969	305,680	135,252	919,901	22,763	942,664		942,664		8
	B. Health Care and Programs										
9	Medical Director			10,500	10,500	25,207	35,707		35,707		9
10	Nursing and Medical Records	2,814,639	92,742	99,044	3,006,425		3,006,425		3,006,425		10
10a	Therapy	4,173		40,215	44,388		44,388		44,388		10a
11	Activities	49,726	481		50,207		50,207		50,207		11
12	Social Services										12
13	CNA Training										13
14	Program Transportation		2,322	1,761	4,083		4,083		4,083		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,868,538	95,545	151,520	3,115,603	25,207	3,140,810		3,140,810		16
	C. General Administration										
17	Administrative	144,268	6,034	335,086	485,388	(230,521)	254,867	(66,711)	188,156		17
18	Directors Fees					8,947	8,947		8,947		18
19	Professional Services			596,185	596,185	22,213	618,398		618,398		19
20	Dues, Fees, Subscriptions & Promotions			9,206	9,206	57,498	66,704	(460)	66,244		20
21	Clerical & General Office Expenses	152,966		12,194	165,160	12,295	177,455		177,455		21
22	Employee Benefits & Payroll Taxes			792,289	792,289	62,225	854,514		854,514		22
23	Inservice Training & Education										23
24	Travel and Seminar			16,567	16,567	11	16,578	(1,945)	14,633		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			47,905	47,905		47,905		47,905		26
27	Other (specify):*			(143,724)	(143,724)		(143,724)	143,724			27
28	TOTAL General Administration	297,234	6,034	1,665,708	1,968,976	(67,332)	1,901,644	74,608	1,976,252		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,644,741	407,259	1,952,480	6,004,480	(19,362)	5,985,118	74,608	6,059,726		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:

07/01/2010

Ending:

06/30/2011

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			229,820	229,820	313	230,133		230,133			30
31	Amortization of Pre-Op. & Org.			15,309	15,309		15,309		15,309			31
32	Interest			670,155	670,155	17,211	687,366	(19,678)	667,688			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds					1,838	1,838		1,838			34
35	Rent-Equipment & Vehicles			31,758	31,758		31,758		31,758			35
36	Other (specify):*											36
37	TOTAL Ownership			947,042	947,042	19,362	966,404	(19,678)	946,726			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			362,960	362,960		362,960		362,960			42
43	Other (specify):*	1,192,660	4,223	7,352	1,204,235		1,204,235		1,204,235			43
44	TOTAL Special Cost Centers	1,192,660	4,223	370,312	1,567,195		1,567,195		1,567,195			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,837,401	411,482	3,269,834	8,518,717		8,518,717	54,930	8,573,647			45

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

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(19,678)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	130,447	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	13,277	27		24
25	Fund Raising, Advertising and Promotional	(460)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 123,586		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 123,586		37

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

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

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

BHF USE ONLY							
48		49		50		51	
							52

Walter Lawson Children's Home

ID# 0035469

Report Period Beginning: 07/01/2010

Ending: 06/30/2011

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Meals & Entertainment	\$ (1,945)	24
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	(1,945)	49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

07/01/2010

Ending:

06/30/2011

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(66,711)	0	0	0	0	0	0	0	0	0	(66,711)	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	(460)	0	0	0	0	0	0	0	0	0	0	(460)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(1,945)	0	0	0	0	0	0	0	0	0	0	(1,945)	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):*	143,724	0	0	0	0	0	0	0	0	0	0	143,724	27
28	TOTAL General Administration	141,319	(66,711)	0	74,608	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	141,319	(66,711)	0	74,608	29								

STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

07/01/2010 Ending:06/30/2011

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	(19,678)	0	0	0	0	0	0	0	0	0	0	(19,678) 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	(19,678)	0	0	0	0	0	0	0	0	0	0	(19,678) 37
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	121,641	(66,711)	0	54,930 45								

Facility Name & ID Number Walter Lawson Children's Home

0035469

Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		Swann Specail Care Center	Champaign			
		Exceptional Care & Training Center	Sterling			
		Vernon Manor Childrens Home	Wabash, Indiana			
		Richland-Bean Blossom HCC	Ellettsville, Indiana			
		Exceptional Living Centers of Brazil	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	\$ 297,232	Hoosier Care, Inc.	100.00%	\$ 230,521	\$	(66,711)	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total		\$ 297,232			\$ 230,521	\$ *	(66,711)	14

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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number

Walter Lawson Children's Home

#

0035469

Report Period Beginning:

07/01/2010

Ending:

06/30/2011

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				Director Fee	\$ 1,428	18 / 3	1
2	Stephen Wood	Director	Board Meetings	0.00				Director Fee	4,459	18 / 3	2
3	John Gillmor	Director	Board Meetings	0.00				Director Fee	1,632	18 / 3	3
4	John Foos	Director	Board Meetings	0.00				Director Fee	1,428	18 / 3	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 8,947		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:

07/01/2010

Ending: 6/30/2011

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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	49,258,737	7	\$ 114,973	\$ 8,876,535	\$ 20,718	1
2	5	Heat & Other Utilities	Revenue	49,258,737	7	5,016	8,876,535	904	2
3	6	Maintenance	Revenue	49,258,737	7	6,331	8,876,535	1,141	3
4	10	Nursing/Medical Records	Revenue	49,258,737	7	139,883	8,876,535	25,207	4
5	18	Directors Fees	Revenue	49,258,737	7	49,648	8,876,535	8,947	5
6	19	Professional Services	Revenue	49,258,737	7	123,265	8,876,535	22,213	6
7	20	Dues, Subscriptions & Fees	Revenue	49,258,737	7	319,030	8,876,535	57,490	7
8	21	Clerical General Office Exp.	Revenue	49,258,737	7	68,230	8,876,535	12,295	8
9	22	Emp. Benefits & Payroll	Revenue	49,258,737	7	345,306	8,876,535	62,225	9
10	24	Travel & Seminar	Revenue	49,258,737	7	108	8,876,535	19	10
11	30	Depreciation	Revenue	49,258,737	7	1,735	8,876,535	313	11
12	32	Interest-Working Capital	Revenue	49,258,737	7	95,510	8,876,535	17,211	12
13	34	Rent- Facility	Revenue	49,258,737	7	10,200	8,876,535	1,838	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					\$ 1,279,235	\$	\$ 230,521	25

Facility Name & ID Number

Walter Lawson Children's Home

0035469

Report Period Beginning:

07/01/2010

Ending:

06/30/2011

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	City of Loves Park - 1999A		X	Purchase of Facility	Varies	7/8/99	\$ 5,500,000	\$ 4,820,000	06/01/2034	7.1250	\$ 347,700	1								
2	City of Loves Park - 1999B		X	Purchase of Facility	Varies	7/8/99	250,000	165,000	06/02/2019	10.5000	18,113	2								
3	Hoosier Care Investments, LLC	X		Addition to Facility	\$25,493.28	3/15/07	3,000,000	2,766,177	04/15/2027	8.2135	249,269	3								
4												4								
5												5								
Working Capital																				
6											17,211	6								
7												7								
8												8								
9	TOTAL Facility Related				\$25,493.28		\$ 8,750,000	\$ 7,751,177			\$ 632,293	9								
B. Non-Facility Related*																				
10	Debt Allocation		X	Purchase of Facility	Varies	7/8/99			Varies	Varies	37,862	10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ 37,862	14								
15	TOTALS (line 9+line14)						\$ 8,750,000	\$ 7,751,177			\$ 687,366	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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1.	Real Estate Tax accrual used on 2010 report.		\$		1
2.	Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$		2
3.	Under or (over) accrual (line 2 minus line 1).		\$		3
4.	Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$		4
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006	_____	8	
		2007	_____	9	
		2008	_____	10	
		2009	_____	11	
		2010	_____	12	
FOR BHF USE ONLY					
		13	FROM R. E. TAX STATEMENT FOR 2010 \$		13
		14	PLUS APPEAL COST FROM LINE 5 \$		14
		15	LESS REFUND FROM LINE 6 \$		15
		16	AMOUNT TO USE FOR RATE CALCULATION \$		16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Walter Lawson Children's Home COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0035469

CONTACT PERSON REGARDING THIS REPORT Charles Smith

TELEPHONE (859) 255-0075 FAX #: (859) 281-5150

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.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X 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: 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:

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

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

Report Period Beginning:

07/01/2010 Ending: 06/30/2011

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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	10-10	\$ 63,425		\$ 1,770,065	4
5	6			2008	3,659,316	91,483	40	91,483		297,319	5
6											6
7											7
8											8
	Improvement Type**										
9		ROOF REPAIRS		1989	1,625		5			1,625	9
10		CARPET FOR EDUCATION OFFI		1990	936		3			936	10
11		CARRIER HEAT/AIR CONDITIO		1990	17,400		5			17,400	11
12		BUILDING IMPROVEMENTS		1991	1,563		10			1,563	12
13		WATER HEATER IMPROVEMENT		1991	961		10			961	13
14		DOORFRAME MOLDING - INTS		1991	528		10			528	14
15		METAL DOOR/KITCHEN DOORS		1991	738		10			738	15
16		SHOWER RENOVATION WATER H		1992	1,749		10			1,749	16
17		HANDRAILS - INST'L PRODUC		1992	584		10			584	17
18		ROOFING - KNOSR & MEYERS		1992	2,258		10			2,258	18
19		INSTALL VALVE - WATER LIN		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		WEATHERSTRIPPING REPLACEM		1994	1,849		10			1,849	24
25		REMODEL LAUNDRY ROOM		1994	2,063		10			2,063	25
26		A/C ROOFTOP UNIT		1994	8,985		10			8,985	26
27		INSTALL SUMP PUMP & MANHO		1994	3,200		10			3,200	27
28		ANTI-SCALD VALVE		1995	696		10			696	28
29		ALARM ANSUL SYSTEM W/HOOD		1995	1,253		10			1,253	29
30		GARBAGE DISPOSAL		1995	1,067		10			1,067	30
31		WATER BOOSTER SYS REPLACE		1995	6,941		10			6,941	31
32		CARPET FOR ALL OFFICES		1995	2,432		10			2,432	32
33		STRIP/SEAL NORTH PARKING		1995	3,382		10			3,382	33
34		ADDITIONAL PARKING SPACE		1995	2,375		10			2,375	34
35		REPLACE GUTTERS & DOWNSPO		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.

See Page 12A, Line 70 for total

**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:

07/01/2010 Ending: 06/30/2011**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	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 THERMAL TITE WINDOW	1996	730		10		730	40
41	REMODEL KITCHEN-CEILING T	1996	279		10		279	41
42	INSTALL WATER HEATER	1996	4,981		10		4,981	42
43	INSTALL HATCO WATER HEATE	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	1997	666		10		666	50
51	DRAIN,LINES,VENT-SHOWER T	1997	1,340		10		1,340	51
52	INSTALL I75WATT FIXTURE,E	1997	1,427		10		1,427	52
53	REPLACED CONTROL BOARD,TE	1997	1,021		10		1,021	53
54	WATER CIRCULATION PUMP	1997	675		10		675	54
55	RE-ROOF NORTH WING,GRAVEL	1997	27,596		10		27,596	55
56	PARKING LOT	1997	9,898		10		9,898	56
57	FENCE ON BACK LOT	1997	5,680		10		5,680	57
58	INSTALL DIRT/SOD RE:PARKI	1997	1,075		10		1,075	58
59	INSTALL A/C 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	285,913	14,296	20	14,296	195,374	62
63	GRADE/SOD AREA RE:NEW ADD	1997	520		10		520	63
64	REPLACED BLOWER MOTOR ON	1997	620		10		620	64
65	POURED CONCRETE IN BOILER	1998	945		10		945	65
66	INSTALL EMERGENCY GENERAT	1998	85,329		10		85,329	66
67	CABINETS & COUNTERTOPS	1998	788		10		788	67
68	REPLACED MOTOR & WHEEL ON	1998	837		10		837	68
69	REPLACE HEAT EXCHANGER,BU	1998	1,228		10		1,228	69
70	TOTAL (lines 4 thru 69)		\$ 7,130,902	\$ 169,204		\$ 169,204	\$ 2,531,431	70

**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.**

1	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		\$ 7,130,902	\$ 169,204		\$ 169,204		\$ 2,531,431	1
2	1998	1,639		10			1,639	2
3	1998	700		10			700	3
4	1998	570		10			570	4
5	1998	9,752		10			9,752	5
6	1998	1,397		10			1,397	6
7	1998	1,008		10			1,008	7
8	1999	4,340		10			4,340	8
9	1999	2,080		10			2,080	9
10	1999	1,780		10			1,780	10
11	1998	676		10			676	11
12	1999	912		10			912	12
13	1999	730		10			730	13
14	1999	2,500	125	20	125		1,500	14
15	1999	3,727	186	20	186		2,174	15
16	1999	3,265	218	15	218		2,540	16
17	2000	730	49	15	49		560	17
18	2000	1,804	120	15	120		1,383	18
19	2000	918	61	15	61		694	19
20	2000	3,264		10			3,264	20
21	2000	6,528		10			6,528	21
22	2000	1,478		10			1,478	22
23	2000	1,147	57	20	57		640	23
24	2000	2,700	180	15	180		1,950	24
25	2000	900	60	15	60		645	25
26	2000	1,600	40	10	40		1,600	26
27	2000	2,445	163	15	163		1,766	27
28	2001	37,774	1,511	25	1,511		15,865	28
29	2001	623	25	25	25		256	29
30	2001	2,200	88	25	88		895	30
31	2001	40,846	1,634	25	1,634		16,611	31
32	2001	900	90	10	90		900	32
33	2001	2,085	139	15	139		1,378	33
34		\$ 7,273,922	\$ 173,950		\$ 173,950		\$ 2,619,642	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:

07/01/2010 Ending: 06/30/2011**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	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		\$ 7,273,922	\$ 173,950		\$ 173,950		\$ 2,619,642	1
2	2001	4,837	322	15	322		3,090	2
3	2001	859	57	15	57		563	3
4	2001	6,594	440	15	440		4,286	4
5	2001	2,341	234	10	234		2,283	5
6	2002	2,341	156	15	156		1,469	6
7	2002	1,485	99	15	99		875	7
8	2002	2,818	188	15	188		1,660	8
9	2002	900	90	10	90		795	9
10	2002	1,356	136	10	136		1,187	10
11	2002	500	50	10	50		433	11
12	2003	1,105	74	15	74		626	12
13	2003	3,541	354	10	354		2,862	13
14	2003	702	70	10	70		568	14
15	2003	639	64	10	64		512	15
16	2004	1,423	142	10	142		1,055	16
17	2004	695	58	7	58		695	17
18	2004	2,576	276	7	276		2,576	18
19	2004	5,880	560	7	560		5,880	19
20	2004	720	103	7	103		685	20
21	2004	198,856	7,954	25	7,954		52,365	21
22	2005	1,941	277	7	277		1,779	22
23	2005	850	57	15	57		354	23
24	2005	1,265	127	10	127		727	24
25	2006	6,376	638	10	638		3,188	25
26	2006	7,600	760	10	760		3,420	26
27	2006	1,172	117	10	117		527	27
28	2008	992	99	10	99		322	28
29	2008	3,973	397	10	397		1,258	29
30	2008	870	87	10	87		275	30
31	2008	864	86	10	86		266	31
32	2007	838	56	15	56		196	32
33	2008	12,588	629	20	629		1,678	33
34		\$ 7,553,419	\$ 188,708		\$ 188,708		\$ 2,718,099	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:

07/01/2010 Ending: 06/30/2011**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	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		\$ 7,553,419	\$ 188,708		\$ 188,708		\$ 2,718,099	1
2	2008	1,230	82	15	82		212	2
3	2008	938	94	10	94		281	3
4	2008	1,500	150	10	150		450	4
5	2008	674	67	10	67		196	5
6	2009	685	69	10	69		166	6
7	2009	1,450	97	15	97		209	7
8	2009	954	95	10	95		167	8
9	2009	580	58	10	58		92	9
10	2009	3,912	391	10	391		619	10
11	2010	1,270	127	10	127		180	11
12	2009	1,496	150	10	150		237	12
13	2010	564	56	10	56		80	13
14	2010	1,359	91	15	91		128	14
15	2010	845	84	10	84		113	15
16	2010	532	53	10	53		66	16
17	2010	2,052	137	15	137		148	17
18	2010	7,019	585	10	585		585	18
19	2011	3,025		10				19
20	2011	624		10				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		\$ 7,584,126	\$ 191,093		\$ 191,093		\$ 2,722,029	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 157,237	\$ 28,265	\$ 28,265	\$		\$ 87,365	71
72	Current Year Purchases	45,171	5,234	5,234			5,234	72
73	Fully Depreciated Assets	634,112	3,557	3,557			634,112	73
74								74
75	TOTALS	\$ 836,520	\$ 37,056	\$ 37,056	\$		\$ 726,711	75

D. Vehicle Costs. (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	1992 Ford Club Wagon	1992	\$ 3,120	\$	\$	\$		\$ 3,120	76
77	Patient Transportation	1992 Ford Van	1992	1,040					1,040	77
78	Patient Transportation	1999 Dodge Van	1999	22,678					22,678	78
79	Patient Transportation	2000 Chevy Van	2000	28,850	1,670	1,670			25,649	79
80	TOTALS			\$ 55,688	\$ 1,670	\$ 1,670	\$		\$ 52,487	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)	\$ 9,160,762	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 229,819	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 229,819	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)	\$ 3,501,227	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: _____

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

If NO, see instructions. YES NO

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

**

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

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

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

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

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2012 \$ _____

13. _____ /2013 \$ _____

14. _____ /2014 \$ _____

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		Contract	Total
		1 Drop-outs	2 Completed		
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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1	
2	Licensed Speech and Language Development Therapist	10a / 3	hrs			40,215				40,215	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			\$		\$ 40,215	\$		\$	40,215	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: 07/01/2010Ending: 06/30/2011

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2011

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 562	\$	1
2	Cash-Patient Deposits	84,184		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,055,284		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	30,596		6
7	Other Prepaid Expenses	3,221		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,173,847	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	948,667		13
14	Buildings, at Historical Cost	7,123,906		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,088,189		16
17	Accumulated Depreciation (book methods)	(3,501,227)		17
18	Deferred Charges	2,338,912		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	902,060		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Goodwill</u>	261,131		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 9,161,638	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 11,335,485	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 141,772	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	84,184		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	295,538		30
31	Accrued Taxes Payable (excluding real estate taxes)	14,400		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	45,962		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Current Portion Bonds Payable</u>	196,949		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 778,805	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	8,651,592		41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 8,651,592	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 9,430,397	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,905,088	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 11,335,485	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,527,592	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,527,592	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	377,496	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)	\$ 377,496	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)	\$ 1,905,088	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	\$ 7,351,920	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,351,920	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	1,421,922	9
10	Other Government Grants	74,881	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		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,496,803	23
D. Non-Operating Revenue			
24	Contributions	23,679	24
25	Interest and Other Investment Income***	19,678	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 43,357	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)	1,959	27
28	<u>Miscellaneous Income</u>	2,174	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,133	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,896,213	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	919,901	31
32	Health Care	3,115,603	32
33	General Administration	1,968,976	33
B. Capital Expense			
34	Ownership	947,042	34
C. Ancillary Expense			
35	Special Cost Centers	1,204,235	35
36	Provider Participation Fee	362,960	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,518,717	40
41	Income before Income Taxes (line 30 minus line 40)**	377,496	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 377,496	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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:

07/01/2010

Ending:

06/30/2011

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	2,086	2,222	\$ 102,478	\$ 46.12	1
2	Assistant Director of Nursing					2
3	Registered Nurses	19,211	20,926	588,151	28.11	3
4	Licensed Practical Nurses	19,892	22,244	599,719	26.96	4
5	CNAs & Orderlies	117,964	127,243	1,524,291	11.98	5
6	CNA Trainees					6
7	Licensed Therapist	53	57	4,173	73.21	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,863	2,117	31,880	15.06	9
10	Activity Assistants	1,911	2,028	17,846	8.80	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,885	2,130	42,005	19.72	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,563	12,595	134,022	10.64	15
16	Dishwashers					16
17	Maintenance Workers	1,931	2,072	44,627	21.54	17
18	Housekeepers	12,072	13,271	176,725	13.32	18
19	Laundry	7,800	8,437	81,590	9.67	19
20	Administrator	2,030	2,161	144,268	66.76	20
21	Assistant Administrator					21
22	Other Administrative	5,467	6,119	152,966	25.00	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction	46,154	50,479	914,737	18.12	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	3,935	4,284	70,801	16.53	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>	14,974	15,910	207,122	13.02	33
34	TOTAL (lines 1 - 33)	270,791	294,295	\$ 4,837,401 *	\$ 16.44	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	\$ 11,360	1 / 3	35
36	Medical Director	10,500	9 / 3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	3,069	10 / 3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify) <u>Dental Fees</u>	5,757	10 / 3	46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 30,686		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$ 1,110	10 / 3	50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	\$ 1,110		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Theo Brandel	Administrator	0	\$ 144,268	Workers' Compensation Insurance	\$ 62,249	IDPH License Fee	\$	
				Unemployment Compensation Insurance		Advertising: Employee Recruitment	630	
				FICA Taxes	371,281	Health Care Worker Background Check (Indicate # of checks performed)	968	
				Employee Health Insurance	340,220	Patient Background Checks		
				Employee Meals		PR Census	460	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	7,156	
				Employee Retirement Plan	10,149	Corporate Allocation	57,490	
				Employee Benefits Other	8,390			
				Corporate Allocation	62,225			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 144,268			Less: Public Relations Expense	(460)	
B. Administrative - Other						Non-allowable advertising	()	
Description			Amount			Yellow page advertising	()	
Equipment - Small Purchases / Repairs & Maint			\$ 2,350					
Taxes, Licenses, Other			640					
Auto Expnese			2,331					
Resident Concern			64					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 5,385					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
BKD, LLP	Accounting Fees		\$ 5,045				Out-of-State Travel	\$
Medical Rehabilitation Centers	Management Fees		556,800				Corporate Home Office ED meeting	2,670
Duane Morris	Legal Fees		18,118				Corporate Allocation	19
Wessels Sherman	Legal Fees		644				In-State Travel	5,307
MRC	Legal Fees		14,798				Meals & Entertainment	1,945
Taft, Stettinius & Hollister, LLP	Legal Fees		155					
DeWitt Ross & Stevens	Legal Fees		134				Seminar Expense	
Stites & Harbison PLLC	Legal Fees		491				Silver Chair core curriculum-education	4,500
							IAASE conf / ISBE IHCA /	1,028
							Behaviorial / Policy Tech / Misc	1,109
							Entertainment Expense	(1,945)
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 596,185	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$ 14,633

* 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.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Walter Lawson Children's Home# 0035469Report Period Beginning: 07/01/2010Ending: 06/30/2011**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. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes 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? _____
- (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. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 362,960
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (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? _____ If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? Yes
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (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

Walter Lawson Children's Home
Schedule of Reclassifications
FYE 6/30/2011

Account	Descriptor	Reclassifications		Sche X Line #
		Increase	Decrease	
61200	Inservice Seminars		7.95	24
61300	PR Census	7.95		20

Walter Lawson Children's Home
 Schedule V Line 24
 FYE 6/30/2011

Dept	Job	Account	Reference	Description	Amount	Page	Line	Col
6160	00000	61200	61600000061200	Inservice, Seminars, Etc.	6,645	3	24	3
6160	00000	61210	61600000061210	Travel	7,977	3	24	3
6160	00000	61222	61600000061222	Meals & Entertainment	1,945	3	24	3
Total Line 24					16,567			

Walter Lawson Children's Home
 Schedule V Line 27
 FYE 6/30/2011

Dept	Job	Account	Reference	Description	Amount	Page	Line	Col
6160	00000	61230	61600000061230	Indigent Care	(13,277)	3	27	3
6160	00000	61240	61600000061240	Contributions	(130,447)	3	27	3
Total Line 27					(143,724)			

Walter Lawson Children's Home
 Schedule V Line 43
 FYE 6/30/2011

Dept	Job	Account	Reference	Description	Amount	Page	Line	Col
6020	00000	61941	60200000061941	Overtime Wages	20	4	43	1
6020	00000	61941	60200000061941	Overtime Wages	2,166	4	43	1
6020	00000	61942	60200000061942	Sick Time/Leave Reserve	687	4	43	1
6020	00000	61943	60200000061943	Premium Pay Wages	102	4	43	1
6020	00000	61943	60200000061943	Premium Pay Wages	737	4	43	1
6020	00000	61944	60200000061944	Paid Time Off Wages	3,331	4	43	1
6020	00000	61944	60200000061944	Paid Time Off Wages	9,279	4	43	1
6020	00000	61945	60200000061945	Salaries & Wages	32,262	4	43	1
6020	00000	61945	60200000061945	Salaries & Wages	158,538	4	43	1
6030	00000	61941	60300000061941	Overtime Wages	4,297	4	43	1
6030	00000	61941	60300000061941	Overtime Wages	6,792	4	43	1
6030	00000	61941	60300000061941	Overtime Wages	879	4	43	1
6030	00000	61942	60300000061942	Sick Time/Leave Reserve	2,044	4	43	1
6030	00000	61942	60300000061942	Sick Time/Leave Reserve	1,199	4	43	1
6030	00000	61943	60300000061943	Premium Pay Wages	574	4	43	1
6030	00000	61943	60300000061943	Premium Pay Wages	1,513	4	43	1
6030	00000	61943	60300000061943	Premium Pay Wages	251	4	43	1
6030	00000	61944	60300000061944	Paid Time Off Wages	6,895	4	43	1
6030	00000	61944	60300000061944	Paid Time Off Wages	25,893	4	43	1
6030	00000	61944	60300000061944	Paid Time Off Wages	42,118	4	43	1
6030	00000	61944	60300000061944	Paid Time Off Wages	6,119	4	43	1
6030	00000	61945	60300000061945	Salaries & Wages	70,416	4	43	1
6030	00000	61945	60300000061945	Salaries & Wages	330,727	4	43	1
6030	00000	61945	60300000061945	Salaries & Wages	422,269	4	43	1
6030	00000	61945	60300000061945	Salaries & Wages	63,552	4	43	1
6020	00000	61031	60200000061031	Supplies - Other	315	4	43	2
6030	00000	61031	60300000061031	Supplies - Other	3,908	4	43	2
6030	00000	61021	60300000061021	Equipment - Small Purchases	1,346	4	43	3
6030	00000	61022	60300000061022	Equipment - Repairs	5,962	4	43	3
6030	00000	61142	60300000061142	Rent - Equipment	44	4	43	3
Total Line 43					1,204,235			