

VIII. ALLOCATION OF INDIRECT COSTS (continued)

A. Are there any costs included in this report which were derived from allocation of central office or parent organization costs? (See Instructions.)

YES ☒ NO ☐

Name of Related Organization: **Medical Rehabilitation Center, LLC (the Recipient Living Center)**
Street Address: **1001 New Street, Suite 200**
City / State / Zip Code: **Longwood, VA 22081**
Phone Number: **800-433-9372**
Fax Number: **800-201-1108**

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

Walker-Lewis Children Home	225,000
Swain Special Care Center	225,000
Exceptional Care & Training Center	225,000
Comprehensive Living of Illinois	225,000
Rehabilitative Services Healthcare	225,000
Verona Manor Children's Home	225,000
Rehabilitative Nursing Home	225,000
Clarendon Center	225,000
Clarendon Village	225,000
Harbor Healthcare	225,000
Pathway Nursing	225,000
Clarendon Care Center	225,000
Island Center	225,000
Colonial Center	225,000
Armenia Center	225,000

This facility allocation determines the percentage of allowable ELC expenses by building based on the % of each building's operating expenses compared to the total of operating expenses for all facilities under management.

The resulting allowable amount is then grouped by cost report line (for various jurisdictions) on the "Cost Report Grouping" tab.

For Illinois facilities, the amounts must also be adjusted to remove a portion of the gross expense relating to OT and EDU programs. The remaining gross amount attributable to the DMF is then reduced by the percentage by which the gross right fee expense for ELC would be reduced to actual costs per this allocation. See below for U. detail.

Determination of % of Costs to be allocated to each facility under management, % of Total Operating Direct Costs of the Facility to all Facilities under Mgmt

Facility	Operating expenses FY 2015-2016	Facility G: Mgmt FY 2015-2016	Percent Alloc.	Actual Costs
Walker-Lewis Center	4,402,000	478,900	6.75%	305,370 not related
Swain Special Care Center	4,402,000	0	0.00%	0 not related
Total under	4,402,000	478,900	6.75%	305,370
Exceptional Care Center	4,402,000	100,000	1.80%	100,000
Swain Special Care Center	4,402,000	100,000	1.80%	100,000
Comprehensive Living & Rehab	4,402,000	100,000	1.80%	100,000
Subtotal ELC Indiana Facilities	12,604,000	300,000	2.38%	300,000
Training Services	1,111,000	100,000	9.00%	100,000 not related
Swain Care	1,111,000	0	0.00%	0 not related
Subtotal All Indiana Facilities	13,715,000	400,000	2.90%	400,000
Total Allowable Costs	13,715,000	400,000	2.90%	400,000
U: Broad	4,402,000	478,900	4.40%	226,319
Rehabilitative Services	4,402,000	478,900	4.40%	226,319
Rehabilitative Services	4,402,000	478,900	4.40%	226,319
Subtotal ELC Indiana Facilities	12,604,000	300,000	2.38%	300,000
Exceptional Care Training Center	4,402,000	100,000	4.40%	212,643
Swain Special Care Center	4,402,000	100,000	4.40%	212,643
Walker-Lewis Center	4,402,000	100,000	4.40%	212,643
Subtotal ELC Indiana Facilities	12,604,000	300,000	2.38%	300,000
Walker	11,111,000	100,000	11.40%	500,000
Pathway	11,111,000	100,000	9.00%	400,000
Comprehensive	11,111,000	100,000	7.20%	300,000
Subtotal ELC Cost	40,000,000	1,000,000	2.50%	1,000,000
Total Member Care	40,000,000	1,000,000	2.50%	1,000,000
Total ELC Facilities under Mgmt	13,715,000	400,000	2.90%	400,000

Note 1: Operating Expense Worksheet for calendar year period regardless of FTE of individual building

Operating Expense equals Operating Expense per Financial Statement. (Only one)

Management Fee per Facility GA

ELC Allocation & Small Amounts for Expenses that are not included in the ELC, but are for the proportional, proportional, proportional

Group G: All City Mgmt Fee Expense	2015-2016	2017	2018	% of Total by Program
Exceptional Care Training Center	300,000	300,000	300,000	80%
Swain Special Care Center	300,000	300,000	300,000	80%
Walker-Lewis	300,000	300,000	300,000	80%
Subtotal ELC ELC ELC ELC	900,000	900,000	900,000	80%
Remaining Amount in Adjusted DMF amt:	300,000	300,000	300,000	20%
Exceptional Care Training Center	300,000	300,000	300,000	20%
Swain Special Care Center	300,000	300,000	300,000	20%
Walker-Lewis	300,000	300,000	300,000	20%

Ratio of Allowable Costs to Unallocated G: Management Fee per Facility Allocation above

Exceptional Care Training Center 80%

Swain Special Care Center 80%

Walker-Lewis 80%

Calculate remaining allowable related party management fee (Total)

Exceptional Care Training Center 100,000

Swain Special Care Center 100,000

Walker-Lewis 100,000

Check: Net adjustment (Benefit) by reducing remaining G: amt to allowable net party cost/functional expenses below:

Exceptional Care Training Center 100,000

Swain Special Care Center 100,000

Walker-Lewis 100,000

Proportionately remaining allowable remaining related party management fee to functional expense categories for final CR presentation:

Exceptional Care Training Center

Percentage of grouped CR Line to total exp

Utilities 0.01%

Maintenance 0.01%

Administration 0.01%

Professional Services 0.01%

Direct Fees, Subscriptions 0.01%

Client & General Office 0.01%

Employee Benefits & Payroll Taxes 0.01%

Insurance Training & Education 0.01%

Talent & Service 0.01%

Other Admin Staff Transportation 0.01%

Insurance 0.01%

Depreciation 0.01%

Interest 0.01%

Rent - Facility & Grounds 0.01%

Rent - Equipment 0.01%

Subtotal ELC Facilities 0.01%

Swain Special Care Center

Percentage of grouped CR Line to total exp

Utilities 0.01%

Maintenance 0.01%

Administration 0.01%

Professional Services 0.01%

Direct Fees, Subscriptions 0.01%

Client & General Office 0.01%

Employee Benefits & Payroll Taxes 0.01%

Insurance Training & Education 0.01%

Talent & Service 0.01%

Other Admin Staff Transportation 0.01%

Insurance 0.01%

Depreciation 0.01%

Interest 0.01%

Rent - Facility & Grounds 0.01%

Rent - Equipment 0.01%

Subtotal ELC Facilities 0.01%

Walker-Lewis Children's Home

Percentage of grouped CR Line to total exp

Utilities 0.01%

Maintenance 0.01%

Administration 0.01%

Professional Services 0.01%

Direct Fees, Subscriptions 0.01%

Client & General Office 0.01%

Employee Benefits & Payroll Taxes 0.01%

Insurance Training & Education 0.01%

Talent & Service 0.01%

Other Admin Staff Transportation 0.01%

Insurance 0.01%

Depreciation 0.01%

Interest 0.01%

Rent - Facility & Grounds 0.01%

Rent - Equipment 0.01%

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	LP Mortgage HUD Loan 2012		X	Purchase of Facility Refi	\$28,956.00	11/01/12	\$ 7,290,000	\$ 6,696,563	11/01/42	0.0254	\$ 172,139	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	GE Healthcare Finance		X	Working Capital		06/24/14	5,750,000		10/27/19	Varies		6	
7												7	
8												8	
9	TOTAL Facility Related				\$28,956.00		\$ 13,040,000	\$ 6,696,563			\$ 172,139	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 13,040,000	\$ 6,696,563			\$ 172,139	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 33,883 Line # 36

* 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.)

B. Real Estate Taxes

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.

FACILITY NAME	<u>Walter Lawson Childrens Home</u>	COUNTY	<u>Winnebago</u>
---------------	-------------------------------------	--------	------------------

CONTACT PERSON REGARDING THIS REPORT _____

A. Summary of Real Estate Tax Cost

(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. N/A - Tax Exempt		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

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.)

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.**

A. Square Feet: 37,782

B. General Construction Type: Exterior BrickFrame WoodNumber 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).
[WLCH Developmental Day Training Program and Special Education Programs; cost removal adjustments & allocation to remove associated costs shown on SCH V; See Pg 11.2 for further detail.](#)

E. Does this cost report reflect any organization or pre-operating costs which are being amortized?
If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	SNF/PED	217,364	1989	\$ 684,428	1
2					2
3	TOTALS	217,364		\$ 684,428	3

Facility Name & ID Number

Walter Lawson Childrens Home # 0035469 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

Walter Lawson Childrens Home

Schedule X Supplemental Schedule

Item 14 - Allocation of non-long term care costs

(E)

Walter Lawson Children's Home operates Education and Developmental Day Training programs in dedicated spaces within the same physical building as the skilled nursing facility. Costs specifically attributable to these programs in dedicated GL accounts, including wages/salaries, supplies, etc. have been grouped in line 39 of Schedule V, "Ancillary Service Centers", and are removed via adjustment on Schedule VI, Line 3.

In addition, a portion of all other cost centers and expense items which provide benefits and support to the Education and Day Training programs are removed via adjustment on Schedule VI, Line 29. The following allocation methodology is utilized:

Costs incurred which benefit multiple operational programs are identified, segregated, and reported each year in conjunction with required cost report filings to the Illinois Purchased Care Review Board for the Educational program. The percentage of costs identified for each program from the most recent ILPCRB report are utilized to calculate the portion attributable to Day Training and Education which is removed in this Cost Report. A percentage of wages and salaries expense, identifiable to each specific program and position, is utilized to allocate Employee benefits and payroll taxes. Hours of operation of each program are utilized to allocate certain administrative, overhead, and support services. Square footage dedicated to each operation is utilized to allocate depreciation, interest, and other capital items, and other allocation bases are utilized for applicable shared costs.

The results of these allocations appear on Schedule VI, as adjustments to remove shared costs attributable to non-long term care services.

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	10-40	\$ 63,425	\$	2,087,190	4
5	6			2008	3,659,316	91,483	40	91,483		754,734	5
6											6
7											7
8											8
	Improvement Type**										
9	Pipe Repair/Kitchen Floor Re			9/1/2014	3,100.00	310.00	10	310		568.33	9
10	Replace Rooftop Heating & Co			11/14/2014	6,291.00	629.10	10	629		1,048.50	10
11	Water Conditioners			2/16/2015	10,360.00	1,036.00	10	1,036		1,381.33	11
12	Radiator Assembly			3/19/2015	3,855.58	385.56	10	386		481.95	12
13	Concrete/Drainage Work			9/21/2015	15,060.00	1,129.50	10	1,130		1,129.50	13
14	Masonry Work			10/29/2015	2,550.00	170.00	10	170		170.00	14
15	Water Heater			11/18/2015	10,850.00	632.92	10	633		632.92	15
16	CARRIER HEAT/AIR CONDITIO			1/11/1990	17,400.00	-	5			17,400.00	16
17	REMODEL LAUNDRY ROOM			2/1/1994	3,153.98	-	10			3,153.98	17
18	A/C ROOFTOP UNIT			7/1/1994	8,985.00	-	10			8,985.00	18
19	INSTALL NEW WINDOWS			12/20/1995	2,587.50	-	10			2,587.50	19
20	TILE KITCHEN FLOOR			1/31/1996	5,187.00	-	10			5,187.00	20
21	INSTALL WATER HEATER			3/19/1996	4,981.25	-	10			4,981.25	21
22	INSTALL WATER HEATER			2/11/1997	6,014.21	-	10			6,014.21	22
23	SHOWER TROLLEY			3/11/1997	10,923.53	-	10			10,923.53	23
24	RE-ROOF NORTH WING, GRAVEL			6/18/1997	27,596.00	-	10			27,596.00	24
25	INSTALL A/C ROOF-TOP UNIT			7/16/1997	2,975.00	-	10			2,975.00	25
26	INSTALL EMERGENCY GENERAT			1/12/1998	85,329.00	-	10			85,329.00	26
27	NEW ROOF TOP HVAC UNIT			1/19/1999	4,340.00	-	10			4,340.00	27
28	TEAR OFF AND REPLACE ROOF			7/30/1999	2,500.00	125.00	20	125		2,125.16	28
29	INSTALL NEW ROOF SHINGLES			11/1/1999	3,727.00	186.35	20	186		3,105.87	29
30	INSTALL			11/29/1999	3,265.00	-	15			3,265.00	30
31	PARTIAL PMT-TELEPHONE SYS			3/27/2000	3,264.02	-	10			3,264.02	31
32	PARTIAL PMT-TELEPHONE SYS			3/27/2000	6,528.04	-	10			6,528.04	32
33	FIRE SPRINKLER SYSTEM.			1/15/2001	37,774.00	1,510.96	25	1,511		23,419.78	33
34	DURO-LAST ROOF SYSTEM.			5/15/2001	40,846.00	1,633.84	25	1,634		24,779.82	34
35	DONATION OF NURSE			10/1/2001	6,594.00	439.60	15	440		6,484.03	35
36	BOOSTER PUMP			12/31/2001	4,837.00	322.47	15	322		4,702.64	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Walter Lawson Childrens Home

0035469

Report Period Beginning:

07/01/2015 Ending: 06/30/2016

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 NEW HEAT EXCHANGER,INDUCE	9/20/2002	\$ 2,818.15	\$ 187.88		\$ 188		\$ 2,599.04	37
38 REMODELING PROJECT	6/30/2003	3,540.80	-				3,540.80	38
39 New flooring in 2 rooms	4/10/2004	2,576.00	-				2,576.00	39
40 therapy room/spa	11/30/2004	198,856.36	7,954.25		7,954		92,136.73	40
41 Water heater (75 gallon)	6/30/2006	6,375.89	637.58		638		6,375.89	41
42 HVAC unit for B wing	12/19/2006	7,600.00	760.00		760		7,220.00	42
43 Rooftop hvac unit	4/24/2008	3,973.00	397.30		397		3,244.62	43
44 Induct air purifiers (12)	12/7/2009	3,911.91	391.19		391		2,575.33	44
45 A.O. Smith water heater	8/17/2010	7,018.87	701.89		702		4,094.36	45
46 Sentronic door closers (2) f	6/23/2011	3,025.00	302.50		303		1,512.50	46
47 Rpl roof and ceiling in main	1/20/2012	5,450.00	545.00		545		2,407.08	47
48 Remodel C wing bathing room	12/16/2011	10,848.33	723.22		723		3,254.49	48
49 West side siding, maint. sho	4/18/2012	4,929.00	492.90		493		2,053.75	49
50 Kitchen & dining room remode	3/9/2012	19,090.40	1,272.69		1,273		5,514.99	50
51 Exterior lights, interior re	7/20/2012	3,304.38	330.44		330		1,294.22	51
52 Roof top units (2)	11/19/2012	12,680.00	1,268.00		1,268		4,543.67	52
53 BLACKTOP DRIVEWAY	11/24/1993	10,130.00	-				10,130.00	53
54 STRIP/SEAL NORTH PARKING	9/25/1995	3,382.00	-				3,382.00	54
55 PARKING LOT	9/22/1997	9,898.00	-				9,898.00	55
56 FENCE ON BACK LOT	10/7/1997	5,680.00	-				5,680.00	56
57 BLACKTOP NEW PARKING,DRIV	7/9/1998	9,752.00	-				9,752.00	57
58 REPLACE CONCRETE AT PAVIL	9/15/2000	2,700.00	30.00		30		2,700.00	58
59 Drywell	11/12/2008	12,588.00	629.40		629		4,825.40	59
60 Concrete gazebo floor & walk	5/11/2012	10,120.50	1,012.05		1,012		4,216.88	60
61 2 F2900 Controllors and Resi	2/25/2004	5,880.00	-				5,880.00	61
62 INSTALL SUMP PUMP & MANHO	10/19/1994	3,200.00	-				3,200.00	62
63 WATER BOOSTER SYS REPLACE	1/30/1995	6,941.00	-				6,941.00	63
64 INSTALL NEW MIXING VALVE	4/26/1996	2,960.00	-				2,960.00	64
65								65
66 Day Training/Education Assets Disallowed (See 5A)			(99,369)		(99,369)			66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 7,296,420	\$ 81,687		\$ 81,687	\$	\$ 3,318,992	70

**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	\$ 99,025	\$ 19,285	\$ 19,285	\$	3-7	\$ 65,896	71
72	Current Year Purchases	26,670	1,665	1,665		5-7	1,665	72
73	Fully Depreciated Assets	618,388	3,419	3,419		3-10	618,388	73
74	Depr Exp - Rel Pty Alloc Sch VIII		3,393	3,393				74
75	TOTALS	\$ 744,083	\$ 27,762	\$ 27,762	\$		\$ 685,949	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	2012 Ford E250 Van w/ Lift	2012	\$ 40,670	\$ 8,134	\$ 8,134	\$	5	\$ 33,214
77									
78									
79									
80	TOTALS			\$ 40,670	\$ 8,134	\$ 8,134	\$		\$ 33,214

E. Summary of Care-Related Assets				1	2
		Reference			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)			\$ 8,765,601
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$ 117,583
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$ 117,583
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$ 4,038,155

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	Transportation Equip Not Allowed	\$ 54,648	\$	\$ 54,648
87	Assets below IL Capital Threshold	431,140	17,640	366,142
88	Other Assets Disallowed	285,913	14,301	266,853
89				
90				
91	TOTALS	\$ 771,701	\$ 31,941	\$ 687,643

G. Construction-in-Progress		
	Description	Cost
92	Marketplace implementation	\$ 284
93		
94		
95		\$ 284

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Not Applicable - Facility Leased from 100% Commonly-owned Related Party (See Sch VII)
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	Corp Grp Office Allocation		N/A	12/1/2011	7,519	10	10	6
7	TOTAL				\$ 7,519			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: \$ 5,089
- Description: Postage Meter: \$899; Short Term Medical Equip: \$3,759; Corp Alloc: \$431
- (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 12/1/2011
Ending 12/1/2021

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

	Fiscal Year Ending	Annual Rent
12.	<u>6/30/2017</u>	\$ <u>Corp Alloc Amt</u>
13.	<u>6/30/2018</u>	\$ <u>Corp Alloc Amt</u>
14.	<u>6/30/2019</u>	\$ <u>Corp Alloc Amt</u>

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☒

☐

☐

50

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☒

☐

80

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		1,134		1,134
3	Classroom Wages (a)		19,475		19,475
4	Clinical Wages (b)		31,160		31,160
5	In-House Trainer Wages (c)		8,395		8,395
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 60,164	\$	\$ 60,164
10	SUM OF line 9, col. 1 and 2 (e)	\$ 60,164			

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	41
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	41

(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.)										
		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		532	37,205		532	37,205	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.1	2120 hrs	80,196				2,120	80,196	4
5	Physician Care		visits							5
6	Dental Care	39.3	visits		12	600		12	600	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39.3	# of prescrpts		52	3,375		52	3,375	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			\$ 80,196	596	\$ 41,180	\$	2,716	\$ 121,376	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.

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	\$ 500	\$ 1,100	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 19,249)	870,773	875,363	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	(20,640)	6,818	6
7	Other Prepaid Expenses	4,400	4,400	7
8	Accounts Receivable (owners or related parties)	6,713,643	6,713,643	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 7,568,676	\$ 7,601,324	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		684,428	13
14	Buildings, at Historical Cost		7,723,582	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost		1,129,292	16
17	Accumulated Depreciation (book methods)		(4,725,798)	17
18	Deferred Charges		176,489	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		401,976	21
22	Other Long-Term Assets (spe CIP		284	22
23	Other(specify): Goodwill	261,131	261,131	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 261,131	\$ 5,651,384	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,829,807	\$ 13,252,708	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 214,115	\$ 214,631	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		179,461	29
30	Accrued Salaries Payable	459,949	459,949	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,347	7,347	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		14,174	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Intercompany payables		(22,598)	36
37	Rounding	(3)	(3)	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 681,408	\$ 852,961	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,517,102	40
41	Bonds Payable			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)	\$	\$ 6,517,102	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 681,408	\$ 7,370,063	46
47	TOTAL EQUITY(page 18, line 24)	\$ 7,148,399	\$ 5,882,645	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,829,807	\$ 13,252,708	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,707,055	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,707,055	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,441,344	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)	\$ 1,441,344	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)	\$ 7,148,399	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Walter Lawson Childrens Home

0035469

Report Period Beginning: 07/01/2015

Ending: 06/30/2016

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

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,948,107	1
2	Discounts and Allowances for all Levels	2	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,948,109	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	1,387,946	9
10	Other Government Grants	54,123	10
11	CNA Training Reimbursements	63,060	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)	\$ 1,505,129	23
	D. Non-Operating Revenue		
24	Contributions	114,455	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 114,455	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)	(820)	27
28	Day Training	939,665	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 938,845	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,506,538	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	906,333	31
32	Health Care	3,290,241	32
33	General Administration	1,760,633	33
	B. Capital Expense		
34	Ownership	555,273	34
	C. Ancillary Expense		
35	Special Cost Centers	1,135,582	35
36	Provider Participation Fee	417,132	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,065,194	40
41	Income before Income Taxes (line 30 minus line 40)**	1,441,344	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,441,344	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 6,948,109	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,948,109	49

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

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

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

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

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	1,928	2,170	\$ 146,271	\$ 67.41	1
2	Assistant Director of Nursing					2
3	Registered Nurses	20,236	22,296	712,914	31.97	3
4	Licensed Practical Nurses	17,188	19,214	658,069	34.25	4
5	CNAs & Orderlies	103,845	112,277	1,311,953	11.68	5
6	CNA Trainees					6
7	Licensed Therapist	1,915	2,120	80,196	37.83	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,708	1,950	32,156	16.49	9
10	Activity Assistants	3,753	3,964	34,547	8.72	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,990	2,136	41,507	19.43	13
14	Head Cook	4,560	4,994	70,182	14.05	14
15	Cook Helpers/Assistants	3,007	3,245	30,606	9.43	15
16	Dishwashers					16
17	Maintenance Workers	3,877	4,139	55,210	13.34	17
18	Housekeepers	14,449	15,842	184,277	11.63	18
19	Laundry	7,885	8,377	81,170	9.69	19
20	Administrator	2,012	2,172	136,671	62.92	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,008	4,445	94,680	21.30	24
25	Vocational Instruction	54,545	59,340	1,047,124	17.65	25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	246,906	268,681	\$ 4,717,533 *	\$ 17.56	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	294	\$ 12,113	1.3	35
36	Medical Director	N/A	12,000	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				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)				46
47					47
48	Note: Medical Dir paid flat fee, not hourly				48
49	TOTAL (lines 35 - 48)	294	\$ 24,113		49

C. CONTRACT NURSES

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

STATE OF ILLINOIS

Facility Name & ID Number

Walter Lawson Childrens Home

0035469

Report Period Beginning:

07/01/2015

Page 21

Ending: 06/30/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Melissa Thornbloom	Administrator	0	\$ 136,671
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 136,671

B. Administrative - Other

Description	Amount
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$

C. Professional Services

Vendor/Payee	Type	Amount
Medical Rehab (dba Ex Living Ctrs)	Management Services	\$ 491,052
ADP / Paycor	Payroll Processing	18,834
Various	Accounting/audit services	16,348
Various (see 21.1 for detail)	Legal services	12,342
VCPI, PhonesPlus	Information Tech Services	4,325
Various	Admin svcs, document svcs	1,231
See Pg 6 for Mgmt Svc Adj		
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 544,132

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 70,395
Unemployment Compensation Insurance	20,294
FICA Taxes	247,871
Employee Health Insurance	368,865
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Retirement Plan	260
Group Allocation - Pg 8	26,070
Less Pg5A Adj for Unallowable DT/EDU	(161,765)
TOTAL (agree to Schedule V, line 22, col.8)	\$ 571,989

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
None.		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$
Advertising: Employee Recruitment	2,948
Health Care Worker Background Check (Indicate # of checks performed 115)	5,733
Public Rel/Mkting/Fundraising	13,261
Bank Fees	44,181
Other Dues, Fees, Subs	(24,366)
Group Allocation - Pg8	1,051
Less Pg5A Adj for Unallowable DT/EDU	(23,078)
Less: Public Relations Expense	(13,261)
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 6,469

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$ 0
N/A	
In-State Travel	
See Page 21.2 for Detail	2,437
SCH VI Adj - Unallowable items	(125)
Corporate/Group Travel Alloc - G&A	22,900
Seminar Expense	
SCH VI Adj - DT/EDU Alloc	(345)
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 24,867

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

Facility Name & ID Number

Walter Lawson Childrens Home

0035469

Report Period Beginning: 07/01/2015

Ending: 06/30/2016

Walter Lawson Childrens Home
Schedule XIX Supplemental Schedule
Legal Fees Detail

DATE	DESCRIPTION	Amount
1 Legal Fees detail for SCH XIX-C		
8/19/2015	Baker, Donelson, Bearman, Caldwell & Berkow	53.32
8/26/2016	Duane Morris LLP	34.00
9/22/2015	Baker, Donelson, Bearman, Caldwell & Berkow	796.50
11/23/2015	SmithAmundsen	75.00
12/14/2015	Duane Morris LLP	22.67
2/5/2016	Baker, Donelson, Bearman, Caldwell & Berkow	160.00
2/29/2016	Baker, Donelson, Bearman, Caldwell & Berkow	195.33
2/29/2016	Baker, Donelson, Bearman, Caldwell & Berkow	387.16
2/29/2016	Baker, Donelson, Bearman, Caldwell & Berkow	155.42
7/14/2015	Stites&Harbison PLLC	22.00
10/19/2015	Stites&Harbison PLLC	4.68
10/19/2015	Stites&Harbison PLLC	7.02
5/17/2016	Stites&Harbison PLLC	51.95
7/31/2015	In-House Counsel Legal Fees	784.30
8/31/2015	In-House Counsel Legal Fees	864.19
9/30/2015	In-House Counsel Legal Fees	757.61
10/31/2015	In-House Counsel Legal Fees	759.68
11/30/2015	In-House Counsel Legal Fees	802.56
12/31/2015	In-House Counsel Legal Fees	720.05
1/31/2016	In-House Counsel Legal Fees	(77.03)
1/31/2016	In-House Counsel Legal Fees	1,014.68
2/29/2016	In-House Counsel Legal Fees	965.95
3/31/2016	In-House Counsel Legal Fees	1,007.68
4/30/2016	In-House Counsel Legal Fees	877.18
5/31/2016	In-House Counsel Legal Fees	957.39
6/30/2016	In-House Counsel Legal Fees	942.37

\$ 12,342

See Schedule VI for adjustment for unallowable portion.

Walter Lawson Childrens Home
Schedule XIX Supplemental Schedule
Travel & Seminar In-State detail:

DESCRIPTION	Amount	SCH V LINE.COL
1 In-State Travel Detail		
Melissa Thornbloom, Exec Dir, care-related in-state travel	2,001	24.3
Wynell Prince Eakle, Regional A/R	A 76	24.3
Kimberly Waterson, Education, in-state travel	A 1	24.3
Corporate/Group travel allocation of operations personnel	A 359	24.3
In-state business meals	A -	24.3
	2,437	
1 Out of State Travel Detail		
n/a	-	24.3
	-	
Line 24 Column 4 Total:	2,437	0
Line 24 Column 7 Adjustment - Corporate/Home Office Allocat	22,900	
Unallowable Amounts above removed through SCH 5 Adjustments:		
A Non-care related amounts noted above:	(436)	
Allocation for non-care-related Education and Day Training	(345)	
(See Pg 11.2 & 5A)		
Line 24 Column 8 Total:	24,556	0

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. ILHCA, \$3,415 net after Schedule VI Adj

(3)

Did the nursing home make political contributions or payments to a political action organization?

No

If YES, have these costs been properly adjusted out of the cost report?

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

No

If YES, what is the capacity?

(5)

Have you properly capitalized all major repairs and equipment purchases?

Yes

What was the average life used for new equipment added during this period?

6 Years

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 93,557

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

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.

\$ 417,132

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?

Yes; See Pg 11.2

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 benefit on Schedule V.

\$

Has any meal income been offset against related costs?

Yes

Indicate the amount.

\$ 54,123

(16)

Travel and Transportation

a. Are there costs included for out-of-state travel?

No

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

No

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$

c. What percent of all travel expense relates to transportation of nurses and patients?

100

d. Have vehicle usage logs been maintained?

Yes

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

Yes

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

Yes

g. Does the facility transport residents to and from day training?

No

Indicate the amount of income earned from providing such transportation during this reporting period.

\$

(17)

Has an audit been performed by an independent certified public accounting firm?

Yes

Firm Name:

Crowe Horwath

(18)

Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

Yes

(19)

Has a schedule for the legal fees reported on the cost report been provided by the facility?

See page 39 of the instructions for details.

Yes

Attach invoices and a summary of services for all architect and appraisal fees