		FOR BHF USE					

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

I. IDPH Facility ID Number: 0020404

Facility Name: WILLIAM L DAWSON NURSING HOME

Address: 3500 SOUTH GILES AVENUE (Number) CHICAGO (City) 60653 (Zip Code)

County: COOK

Telephone Number: (312) 326-2000 **Fax #** (312) 326-5270

HFS ID Number: 36-2477301

Date of Initial License for Current Owners: 1975

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2006 to 12/31/2006 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) PAMELA ORR
(Title) ADMINISTRATOR

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, VICE PRESIDENT
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

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

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME # 0020404 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	245	Skilled (SNF)	245	89,425	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	245	TOTALS	245	89,425	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	371		3,003	3,374	8
9	SNF/PED					9
10	ICF	53,488	1,977		55,465	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	53,859	1,977	3,003	58,839	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.80%

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started / / 1975

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 31 and days of care provided 3,003

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME # 0020404 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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 OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	346,221	82,672	18,355	447,248		447,248	0	447,248			1
2	Food Purchase		327,135		327,135	(64,824)	262,311	(2,034)	260,277			2
3	Housekeeping	63,568	51,673	0	115,241		115,241	0	115,241			3
4	Laundry	103,300	53,392	8,212	164,904	0	164,904	0	164,904			4
5	Heat and Other Utilities			232,652	232,652		232,652	0	232,652			5
6	Maintenance	187,405	24,334	104,615	316,354		316,354	(7,657)	308,697			6
7	Other (specify):*			94,325	94,325		94,325	0	94,325			7
8	TOTAL General Services	700,494	539,206	458,159	1,697,859	(64,824)	1,633,035	(9,691)	1,623,344			8
	B. Health Care and Programs											
9	Medical Director	0		4,800	4,800		4,800	0	4,800			9
10	Nursing and Medical Records	2,686,699	213,737	35,996	2,936,432		2,936,432	0	2,936,432			10
10a	Therapy	33,409	2,458	0	35,867		35,867	0	35,867			10a
11	Activities	110,580	11,194	0	121,774		121,774	0	121,774			11
12	Social Services	81,410		0	81,410		81,410	0	81,410			12
13	CNA Training			0	0		0	0	0			13
14	Program Transportation			0	0		0	0	0			14
15	Other (specify):*				0		0	0	0			15
16	TOTAL Health Care and Programs	2,912,098	227,389	40,796	3,180,283	0	3,180,283	0	3,180,283			16
	C. General Administration											
17	Administrative	381,795		0	381,795		381,795	30,074	411,869			17
18	Directors Fees			0	0		0	0	0			18
19	Professional Services			91,961	91,961		91,961	0	91,961			19
20	Dues, Fees, Subscriptions & Promotions			40,156	40,156		40,156	(15,333)	24,823			20
21	Clerical & General Office Expenses	126,019	46,737	53,802	226,558		226,558	(3,771)	222,787			21
22	Employee Benefits & Payroll Taxes			1,005,842	1,005,842	64,824	1,070,666	(2,860)	1,067,806			22
23	Inservice Training & Education			755	755		755	0	755			23
24	Travel and Seminar			0	0		0	0	0			24
25	Other Admin. Staff Transportation			4,750	4,750		4,750	(1,938)	2,812			25
26	Insurance-Prop.Liab.Malpractice			383,439	383,439		383,439	0	383,439			26
27	Other (specify):*			87,656	87,656		87,656	(87,656)	0			27
28	TOTAL General Administration	507,814	46,737	1,668,361	2,222,912	64,824	2,287,736	(81,484)	2,206,252			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,120,406	813,332	2,167,316	7,101,054	0	7,101,054	(91,175)	7,009,879			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#: WILLIAM L DAWSON NURSING HOME #0020404 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	16,220	
	REPAIRS & MAINTENANCE		2,135	
			0	18,355
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		8,212	
			0	8,212
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		127,645	
	ELECTRICITY		82,597	
	WATER		19,899	
	CABLE TV - LOBBY		2,511	
			0	232,652
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		7,200	
	PAINTING & DECORATING		19,028	
	BUILDING REPAIRS		4,650	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		42,655	
	ELEVATOR MAINTENANCE & REPAIR		11,316	
	OUTSIDE LABOR		665	
	EXTERMINATING SERVICE		9,744	
	FIRE SERVICE		9,357	
	AMORT - DEFERRED DECORATING		0	
			0	
			0	
			0	104,615
7	**OTHER**			
	SCAVENGER		27,010	
	SECURITY SERVICE		67,315	
			0	
			0	94,325
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	4,800	4,800

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	26,291	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		2,384	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,600	
	PHARMACY CONSULTANT	XVIII B 39-2	800	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	4,921	
			0	
			0	35,996
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
			0	0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	0
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME #0020404 **Report Period Beginning:** 01/01/2006 **Ending:** 12/31/2006

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	0	0
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	9,732	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	82,229	
			0	91,961
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	2,971	
	EMPLOYEE WANT ADS	XIX F	2,353	
	CONTRIBUTIONS	VI 20 XIX F	3,245	
	DUES & SUBSCRIPTIONS	XIX F	14,478	
	LICENSES & PERMITS	XIX F	2,767	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	4,665	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	3,888	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	275	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	4,954	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	560	
	PATIENT BACKGROUND CHECKS	XIX F	0	
				40,156
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		256	
	EQUIPMENT REPAIR & MAINTENANCE		10,893	
	OUTSIDE CLERICAL SERVICES		7,006	
	PENALTIES / OVERDRAFT CHARGES	VI 18	3,771	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		626	
	TELEPHONE		30,321	
	MESSENGER SERVICE		929	
			0	53,802

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	314,089	
	UNEMPLOYMENT COMPENSATION	XIX D	103,241	
	WORKERS COMPENSATION INSURANC	XIX D	117,750	
	HOSPITALIZATION INSURANCE	XIX D	433,778	
	EMPLOYEE BENEFITS - OTHER	XIX D	11,384	
	EMPLOYEE PHYSICAL EXAMS	XIX D	477	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	2,860	
	PENSION/PROFIT SHARING PLANS	XIX D	15,091	
	CHICAGO HEAD TAX	XIX D	7,172	
			0	1,005,842
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		755	
				755
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		4,750	
				4,750
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		128,815	
	INSURANCE EXPENSES		165,038	
	INSURANCE SETTLEMENTS		89,586	383,439
27	**OTHER**			
	BAD DEBTS	VI 24	87,656	
				87,656

GRAND TOTAL COLUMN 3 OTHER 2,167,316

WILLIAM L DAWSON NURSING HOME
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2006

TOTAL FOOD PURCHASE	327,135	PATIENT MEALS	176517
LESS SALES TAX	(2,034)	ADD EMPLOYEE MEALS	43800
NET FOOD	325,101	TOTAL MEALS/YEAR	220317
TOTAL PATIENT CENSUS	58,839	NET FOOD	325101
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	220317
TOTAL PATIENT MEALS	176517	COST PER MEAL	1.48
		TIME EMPLOYEE MEALS	43800
ADD # EMPLOYEE MEALS/DAY	120		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	**64824**
TOTAL EMPLOYEE MEALS	43800		

WILLIAM L DAWSON
EQUIPMENT RENTAL PAGE 14 SCHEDULE XII B LINE 16
12/31/2006

PROFESSIONAL MEDICAL	NURSING EQUIPMENT	874
RH MEDICAL	NURSING EQUIPMENT	2,650
PEL/VIP	NURSING EQUIPMENT	2,487
KCI	NURSING EQUIPMENT	8,500
PRISM	WATER TREATMENT	2,178
EMPIRE COOLER SERVICE	ICE MACHINE	3,097
HINCKLEY	WATER COOLER	803
PITNEY BOWES	POSTAGE METER	1,793
IMAGISTICS	OFFICE EQUIPMENT	600
MARLIN LEASING	COPIER	2,862
KINDRED PHARMACY	FAX	48
PUBLIC STORAGE	STORAGE	7,797
		33,689

WILLIAM L DAWSON
PROFESSIONAL FEES PAGE 21 SCHEDULE XIX C
12/31/2006

HDSI	DATA PROCESSING	3,154
ACCU-MED	DATA PROCESSING	3,180
E HEALTH DATA SOLUTIONS	DATA PROCESSING	3,262
EMDEON / MEDIFAX EDI	DATA PROCESSING	135
KBKB	ACCOUNTING	20,550
FR&R	ACCOUNTING	7,750
DISTELDORF LTD	ACCOUNTING	3,445
SACHNOFF & WEAVER	LEGAL	5,961
SONNENSCHEIN NATH & ROSENTHAL	LEGAL	7,273
GOULD & RATNER	LEGAL	5,293
NEAL GERBER & EISENBERG	LEGAL	255
MERIT BENEFIT GROUP	TRUST ADMINISTRATIVE SERVICES	200
EXPERTEK CYBER SOLUTION	ONLINE PAYROLL SUPPORT	310
THEODORE TYLER	APPRAISAL	150
FR&R	MED B BILLING	18,850
PEELO & ASSOC	M/C COST REPORTING	6,000
ILLINOIS APPRAISAL	APPRAISAL	2,500
CITISTREET RETIREMENT SERVICE	401K ADMINISTRATIVE SERVICES	2,690
LEVERGNE MOMAN	INTERIOR DESIGN FEES	1,003
		91,961

WILLIAM L DAWSON
TRANSPORTATION - STAFF
12/31/2006 **ACCT #18370**

	AMER EXPR	ROSA COLLINS PETTY CASH	SECY OF STATE	TOTAL
JAN	116			116
FEB	157			157
MAR	160			160
APR	167			167
MAY	237			237
JUN	300	100		400
JUL	136			136
AUG	487			487
SEP	189			189
OCT	120			120
NOV	239		78	317
DEC	188	60	78	326
TOTAL	2,496	160	156	**2,812**

banking, maintenance, & activities, transportation

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME #0020404 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			82,004	82,004		82,004	29,185	111,189			30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0			31
32	Interest			127,879	127,879		127,879	(16,889)	110,990			32
33	Real Estate Taxes			283,962	283,962		283,962	0	283,962			33
34	Rent-Facility & Grounds			0	0		0	0	0			34
35	Rent-Equipment & Vehicles			44,932	44,932		44,932	0	44,932			35
36	Other (specify):* MIP INS			8,571	8,571		8,571	0	8,571			36
37	**TOTAL Ownership**			547,348	547,348	0	547,348	12,296	559,644			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		130,156	272,680	402,836		402,836	0	402,836			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			134,138	134,138		134,138	0	134,138			42
43	Other (specify):*				0		0	0	0			43
44	**TOTAL Special Cost Centers**	0	130,156	406,818	536,974	0	536,974	0	536,974			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,120,406	943,488	3,121,482	8,185,376	0	8,185,376	(78,879)	8,106,497			45

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

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME # 0020404 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF 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	29,185	30		9
10	Interest and Other Investment Income	(16,889)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,034)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(1,938)	25		16
17	Non-Care Related Fees	(275)	20		17
18	Fines and Penalties	(3,771)	21		18
19	Entertainment				19
20	Contributions	(8,199)	20		20
21	Owner or Key-Man Insurance	(2,860)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(87,656)	27		24
25	Fund Raising, Advertising and Promotional	(2,971)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(3,888)	20		28
29	Other-Attach Schedule	22,417			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (78,879)		$ 0	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 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)	0		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 0		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (78,879)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

WILLIAM L DAWSON NURSING HOME

ID# 0020404

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ (7,657)	6	1
2	MARKETING SALARIES	30,074	17	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**	22,417		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME # 0020404 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,034)	0	0	0	0	0	0	0	0	0	0	(2,034)	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	(7,657)	0	0	0	0	0	0	0	0	0	0	(7,657)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(9,691)	0	0	0	0	0	0	0	0	0	0	(9,691)	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	30,074	0	0	0	0	0	0	0	0	0	0	30,074	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	(15,333)	0	0	0	0	0	0	0	0	0	0	(15,333)	20
21	Clerical & General Office Expenses	(3,771)	0	0	0	0	0	0	0	0	0	0	(3,771)	21
22	Employee Benefits & Payroll Taxes	(2,860)	0	0	0	0	0	0	0	0	0	0	(2,860)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(1,938)	0	0	0	0	0	0	0	0	0	0	(1,938)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(87,656)	0	0	0	0	0	0	0	0	0	0	(87,656)	27
28	TOTAL General Administration	(81,484)	0	0	0	0	0	0	0	0	0	0	(81,484)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(91,175)	0	0	0	0	0	0	0	0	0	0	(91,175)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME # 0020404 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	29,185	0	0	0	0	0	0	0	0	0	0	29,185	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(16,889)	0	0	0	0	0	0	0	0	0	0	(16,889)	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	12,296	0	0	0	0	0	0	0	0	0	0	12,296	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)	(78,879)	0	0	0	0	0	0	0	0	0	0	(78,879)	45

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME # 0020404 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

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 [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	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			$			$	$ *	14

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

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME # 0020404 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	PAMELA ORR	ADMINISTRATOR	ADMIN	100%	NONE	40	100.00	SALARY	$ 96,445	17-1	1
2	MARJORIE MARTIN	ASST ADMIN	ADMIN	BY	" "	40	100.00	" "	48,585	17-1	2
3	CHERYL MARTIN	CONTROLLER	ACCOUNTING	ATTRIBU-	" "	40	100.00	" "	90,579	17-1	3
4	ROBYN MARTIN	ASST ADMIN	ADM/EMPL REL	TION	" "	20	50.00	" "	30,074	17-1	4
5	" "	ASST ADMIN	MARKETING**	" "	" "	20	50.00	" "	30,074	17-1	5
6	SHERRIE MARTIN	MED RECORDS	MED RECORDS	" "	" "	40	100.00	" "	19,723	10-1	6
7											7
8											8
9			** DISALLOWED ON PAGE 5A LINE 1								9
10											10
11											11
12											12
13								TOTAL	$ 315,480		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 WILLIAM L DAWSON NURSING HOME # 0020404 Report Period Beginning: 01/01/2006 Ending: 2/31/2006

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 [X]

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
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	TOTALS					$	$		$	25

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME # 0020404 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	WELLS FARGO MORTGAGE		X	MORTGAGE	$11,475.49	03/16/04	$ 1,792,800	$	03/16/28	5.8200	$ 99,955	1
2	AMORTIZATION-LOAN FEES		X	AMORTIZATION OVER LIFE OF LOAN 288 MONTHS			56,710	50,015			2,363	2
3												3
4												4
5												5
	Working Capital											
6	INSURANCE FINANCING		X	INSURANCE FINANCING							2,331	6
7	MB FINANCIAL		X	LINE OF CREDIT	DEMAND	02/06	350,000	350,000		PRIME+	23,230	7
8												8
9	TOTAL Facility Related				$11,475.49		$ 2,199,510	$ 400,015			$ 127,879	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 0	14
15	TOTALS (line 9+line14)						$ 2,199,510	$ 400,015			$ 127,879	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 8,571 Line # 36-3

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

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

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME # 0020404 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2005 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 281,050	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.)		$ 281,102	2
3. Under or (over) accrual (line 2 minus line 1).		$ 52	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 283,910	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.		$ 283,962	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2001	300,094	8
	2002	303,459	9
	2003	272,222	10
	2004	278,269	11
	2005	281,102	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2005 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2005	$	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.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WILLIAM L DAWSON NURSING HOME COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0020404

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

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

Enter the tax index number and real estate tax assessed for 2005 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 2005.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	17-34-310-002-0000	NURSING HOME	$ 3,078.30	$ 3,078.30
2.	17-34-310-003-0000	NURSING HOME	$ 1,506.08	$ 1,506.08
3.	17-34-310-004-0000	NURSING HOME	$ 1,452.31	$ 1,452.31
4.	17-34-310-055-0000	NURSING HOME	$ 274,108.63	$ 274,108.63
5.	17-34-310-056-0000	NURSING HOME	$ 239.24	$ 239.24
6.	17-34-310-057-0000	NURSING HOME	$ 478.42	$ 478.42
7.	17-34-310-058-0000	NURSING HOME	$ 239.24	$ 239.24
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 281,102.22	$ 281,102.22

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 & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

PLEASE NOTE: Payment information from the Internet or otherwise is not comsidered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME # 0020404 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 67,185 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 4 + BASEMENT

C. Does the Operating Entity? [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	39,156	1974	$ 149,500	1
2	PARKING LOT			11,683	2
3	TOTALS	39,156		$ 161,183	3

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME # 0020404 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	245		1975	1974	$ 955,670	$ 19,113	30	$	$ (19,113)	$ 955,670	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	COMPONENTS			1975	1,228,016		30			1,228,016	9
10	ELEVATOR			1975	97,338		20			97,338	10
11	SPRINKLER			1977	9,699		20			9,699	11
12	FREEZER REPAIRS-AUDIT ADJ NOT ON BALANCE SHEET			1984	33,981		20			33,981	12
13	LINEN CHUTES			1985	1,925		15			1,925	13
14	ROOF REPAIRS			1985	32,489		20			32,489	14
15	AIR LOUVERS			1986	2,156		20	50	50	2,156	15
16	BRAILLE PLATES			1986	2,150		15			2,150	16
17	REG. VALVE			1987	2,760	88	20	138	50	2,634	17
18	BUILDING IMPROVEMENTS			1988	2,257	118	20	113	(5)	2,093	18
19	BUILDING IMPROVEMENTS			1990	5,052	160	20	253	93	4,083	19
20	BUILDING IMPROVEMENTS			1990	2,416	77	15		(77)	2,416	20
21	BUILDING IMPROVEMENTS			1991	12,963		15	785	785	12,963	21
22	BUILDING IMPROVEMENTS			1992	24,808	788	20	1,240	452	17,551	22
23	BUILDING IMPROVEMENTS			1993	13,446	345	30	448	103	6,048	23
24	BUILDING IMPROVEMENTS			1994	6,469	165	39	166	1	2,116	24
25	PARKING LOT REPAIRS			1994	15,295	1,020	15	1,020		12,749	25
26	WALK-IN FREEZER REPAIRS			1995	2,510	64	39	64		856	26
27	PLUMBING REPAIRS			1995	21,850	560	39	560		6,370	27
28	DOORS/FASCIA			1995	3,872	99	39	99		1,127	28
29	CEILING TILE			1995	90,187	2,312	39	2,312		25,613	29
30	CONCRETE REPAIRS			1995	4,309	287	15	287		3,300	30
31	DRYWALL/COUNTER TOPS/CABINETS/TILE			1996	2,251	58	39	58		626	31
32	ELEVATOR REPAIR			1996	6,833	175	39	175		1,860	32
33	ELEVATOR DOOR REPAIRS			1998	4,517	116	39	116		1,029	33
34	FIRE SYSTEM UPGRADE			1998	3,193	82	39	82		673	34
35	CONCRETE REPAIRS			1998	19,117	490	39	490		4,022	35
36	ROOF REPAIRS			1998	21,150	542	39	542		4,359	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 WILLIAM L DAWSON NURSING HOME # 0020404 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	LAUNDRY ROOM/DAMPERS/PATIO REMODELLING	1999	$ 30,264	$ 776	39	$ 776	$	$ 6,146	37
38	DOORS/LOCKS/ELEVATOR REPAIRS	1999	14,549	373	39	373		2,826	38
39	LAUNDRY RM/HEAT-COOL/CABINETS/LOCKS/AWNING	1999	26,503	680	39	680		5,049	39
40	PLUMBING REPAIRS/FIRE SAFETY UPGRADE/LOCKS	1999	56,650	1,453	39	1,453		10,528	40
41	EMERGENCY ELECTRICAL OUTLETS/FIRE DAMPERS	1999	51,364	1,317	39	1,317		9,375	41
42	ALARM SYSTEM UPGRADE	2000	130,975	3,358	39	3,358		21,153	42
43	PARKING LOT RAMP / STONE WALL	2000	24,335	624	39	624		4,148	43
44	DISINFECTION SYSTEM / BOILERS / ELECTRICAL	2000	47,713	1,223	39	1,223		7,567	44
45	ALARM SYSTEM UPGRADE	2001	57,107	1,464	39	1,464		8,589	45
46	PARKING LOT PAVING	2001	25,000	1,668	15	1,668		9,173	46
47	CARPET TILE INSTALLATION	2002	3,429	88	39	88		422	47
48	DOORS/DOOR REFINISHING	2002	149,707	3,838	39	3,838		17,605	48
49	SINK PARTS/FAUCETS	2002	8,482	217	39	217		895	49
50	ROOF REPLACEMENT	2002	38,000	974	39	974		4,018	50
51	FIRE REG UPGRADE-DAMPERS/DRYWALL/DOORS/LAUNDRY	2003	38,757	994	39	994		3,461	51
52	CONDENSING UNIT	2004	3,396	87	39	87		214	52
53	FIRE CODE ELEVATOR EQUIPMENT/HOT WATER BOOSTER	2005	50,645	1,298	39	1,298		1,572	53
54	FIRE CODE ELEVATOR EQUIPMENT/DOORS	2006	4,371	78	39	78		78	54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,389,926	$ 47,169		$ 29,508	$ (17,661)	$ 2,588,731	70

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

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME # 0020404 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 789,953	$ 26,095	$ 60,794	$ 34,699	8-15 YRS	$ 529,277	71
72	Current Year Purchases	26,836	4,065	1,393	(2,672)	8-10 YRS	1,393	72
73	Fully Depreciated Assets				0			73
74					0			74
75	TOTALS	$ 816,789	$ 30,160	$ 62,187	$ 32,027		$ 530,670	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY VAN	SPORTVAN '86	1985	$ 19,262	$	$	$ 0	4 YRS	$ 19,262	76
77	ADMIN/ETC	SAAB '01	2001	39,868	1,775		(1,775)	4 YRS	39,868	77
78	" "	MERCEDES '05	2004	77,977	2,900	19,494	16,594	4 YRS	48,735	78
79							0			79
80	TOTALS			$ 137,107	$ 4,675	$ 19,494	$ 14,819		$ 107,865	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)	$ 4,505,005	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 82,004	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 111,189	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 29,185	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,227,266	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.

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME # 0020404 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
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				$ 0 **			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: ____ *

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.	/2007	$
13.	/2008	$
14.	/2009	$

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: $ 33,689 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMIN,ETC	2003 MERCEDES	$ 907.38	$ 11,243	17
18					18
19					19
20					20
21	TOTAL		$ 907.38	$ 11,243	21

* 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.

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME # 0020404 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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

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

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

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

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	TOTALS	$ 0	$ 0	$ 0	$ 0
10	SUM OF line 9, col. 1 and 2 (e)	$ 0			

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.

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME # 0020404 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	39-3	hrs	$		$ 101,538	$		$ 101,538	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			71,696			71,696	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			99,446			99,446	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				123,512		123,512	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): LAB / RADIOLOGY	39-2					6,644		6,644	13
14	TOTAL			$		$ 272,680	$ 130,156		$ 402,836	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.

STATE OF ILLINOIS

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME # 0020404 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2006 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 529,552	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 50,000)	1,459,888		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	100,188		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	88,524		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): INSUR/R.E.TAX ESCROW	161,686		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,339,838	$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	161,183		13
14	Buildings, at Historical Cost	2,290,723		14
15	Leasehold Improvements, at Historical Cost	1,065,224		15
16	Equipment, at Historical Cost	953,896		16
17	Accumulated Depreciation (book methods)	(2,992,137)		17
18	Deferred Charges	50,015		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): REPLACEMENT RESERVE	443,177		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,972,081	$ 0	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,311,919	$ 0	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 445,727	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	152,873		28
29	Short-Term Notes Payable	350,000		29
30	Accrued Salaries Payable	171,922		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,847		31
32	Accrued Real Estate Taxes(Sch.IX-B)	283,910		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	3,000		35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,418,279	$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	54,000		39
40	Mortgage Payable	1,696,802		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)**	$ 1,750,802	$ 0	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,169,081	$ 0	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,142,838	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,311,919	$ 0	48

*(See instructions.)

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME # 0020404 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,664,250	1
2	Restatements (describe):		2
3			3
4	ROUNDING	(3)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,664,247	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(461,409)	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	(60,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (521,409)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,142,838	24 *

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

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME # 0020404 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,567,451	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,567,451	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	150,632	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 150,632	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		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)**	$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	16,889	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 16,889	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 0	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,734,972	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,697,859	31
32	Health Care	3,180,283	32
33	General Administration	2,222,912	33
	B. Capital Expense		
34	Ownership	547,348	34
	C. Ancillary Expense		
35	Special Cost Centers	402,836	35
36	Provider Participation Fee	134,138	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES	11,005	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,196,381	40
41	**Income before Income Taxes (line 30 minus line 40)****	(461,409)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (461,409)	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **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 WILLIAM L DAWSON NURSING HOME # 0020404 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	3,653	4,082	$ 139,258	$ 34.12	1
2	Assistant Director of Nursing					2
3	Registered Nurses	14,295	15,269	403,189	26.41	3
4	Licensed Practical Nurses	39,228	44,860	995,548	22.19	4
5	CNAs & Orderlies	111,624	150,235	1,128,981	7.51	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,289	1,660	33,409	20.13	8
9	Activity Director					9
10	Activity Assistants	8,311	9,691	110,580	11.41	10
11	Social Service Workers	4,380	5,041	81,410	16.15	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	31,326	42,069	346,221	8.23	15
16	Dishwashers					16
17	Maintenance Workers	16,059	21,526	187,405	8.71	17
18	Housekeepers	6,851	8,952	63,568	7.10	18
19	Laundry	10,292	14,162	103,300	7.29	19
20	Administrator	1,845	2,085	96,445	46.26	20
21	Assistant Administrator	4,627	5,235	146,186	27.92	21
22	Other Administrative	4,170	4,652	139,164	29.91	22
23	Office Manager					23
24	Clerical	7,819	8,708	126,019	14.47	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,520	1,861	19,723	10.60	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	267,289	340,088	$ 4,120,406 *	$ 12.12	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 16,220	1-3	35
36	Medical Director	O	4,800	9-3	36
37	Medical Records Consultant	N	1,600	10-3	37
38	Nurse Consultant	T	4,921	10-3	38
39	Pharmacist Consultant	H	800	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 28,341		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	703	26,291	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	703	$ 26,291		53

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME # 0020404 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
PAMELA ORR	ADMINISTRATOR	**	$ 96,445
MARJORIE MARTIN	ADMINISTRATIVE	**	48,585
ALLEN SPIFF	ASST ADMIN	0	28,551
ROBYN MARTIN	ASST ADMIN	**	60,148
CURTIS MIREE	ASST ADMIN	0	57,487
CHERYL MARTIN	ADMINISTRATIVE-CFO	**	90,579
	** BY ATTRIBUTION 100%		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 381,795

B. Administrative - Other

Description	Amount
	$ 0
TOTAL (agree to Schedule V, line 17, col. 3)	$

(Attach a copy of any management service agreement)

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		91,961
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 91,961

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 117,750
Unemployment Compensation Insurance		103,241
FICA Taxes		314,089
Employee Health Insurance		433,778
Employee Meals		64,824
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		11,384
EMPLOYEE PHYSICAL EXAMS		477
PENSION/PROFIT SHARING PLANS		15,091
CHICAGO HEAD TAX		7,172
INSURANCE - EXECUTIVE LIFE		2,860
INSURANCE - EXECUTIVE LIFE	VI 21	(2,860)
TOTAL (agree to Schedule V, line 22, col.8)		$ 1,067,806

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,353
Health Care Worker Background Check	560
(Indicate # of checks performed 56)	
Patient Background Checks 0	0
TRUST/FRANCHISE/CONTRIB/ETC	8,474
MARKETING/ADV/PROMO	11,524
LICENSES/DUES/SUBSCRIPTIONS	17,245
TRUST/FRANCHISE/CONTRIB/ETC	(8,474)
Less: Public Relations Expense	(0)
Non-allowable advertising	(2,971)
Yellow page advertising	(3,888)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 24,823

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME # 0020404 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	Amount of Expense Amortized Per Year								
					FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1	PAINT/DECORATING	2004	$ 3,911	3	$	$ 652	$ 1,304	$ 1,304	$ 651	$	$	$	$
2	PAINT/DECORATING	2005	20,684	3			3,447	6,895	6,895	3,447			
3	PAINT/DECORATING	2006	19,028	3				3,172	6,343	6,343	3,171		
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 43,623		$	$ 652	$ 4,751	$ 11,371	$ 13,889	$ 9,790	$ 3,171	$	$

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME # 0020404 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE $12,196**

(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? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **29,398** Line **10-2**

(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. $ **134,138**
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. $ **64,824** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(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? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
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. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **FROST RUTTENBERG & ROTTHBLATT** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **NO** If no, please explain. **NOT YET COMPLETED**

(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 $2500, 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