

Facility Name & ID Number Walter Lawson Childrens Home

0035469 Report Period Beginning: 07/01/2013 Ending: 6/30/2014

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

No Change

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2	99	Skilled Pediatric (SNF/PED)	99	36,135	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED	34,122			34,122
10	ICF				10
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	34,122			34,122

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.43%

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

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

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None.

F. Does the facility maintain a daily midnight census?

Yes

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

YES NO

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

YES NO

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

Date started 08/15/1989

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

YES Date 08/15/1989 NO

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

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: YE 06/30/2014 Fiscal Year: YE 06/30/2014

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

Facility Name & ID Number

Walter Lawson Childrens Home

0035469

Report Period Beginning:

07/01/2013

Ending:

6/30/2014

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	147,457	5,574	24,904	177,935		177,935	(78,897)	99,038		1
2	Food Purchase		53,807		53,807		53,807	(5,919)	47,888		2
3	Housekeeping	193,493	11,345		204,838		204,838	(22,532)	182,306		3
4	Laundry	89,546	4,875	454	94,875		94,875	(10,436)	84,439		4
5	Heat and Other Utilities			92,733	92,733		92,733	(28,418)	64,315		5
6	Maintenance	55,963	10,551	40,716	107,230	10	107,240	(31,972)	75,268		6
7	Other (specify):*										7
8	TOTAL General Services	486,459	86,152	158,807	731,418	10	731,428	(178,174)	553,254		8
	B. Health Care and Programs										
9	Medical Director			13,250	13,250		13,250		13,250		9
10	Nursing and Medical Records	2,842,963	398,352	20,450	3,261,765		3,261,765	(358,794)	2,902,971		10
10a	Therapy	78,077	10,577	40,845	129,499		129,499	(14,245)	115,254		10a
11	Activities	73,465	327		73,792		73,792	(8,117)	65,675		11
12	Social Services										12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,994,505	409,256	74,545	3,478,306		3,478,306	(381,156)	3,097,150		16
	C. General Administration										
17	Administrative	148,402		94,152	242,554	124,167	366,721	(42,480)	324,241		17
18	Directors Fees										18
19	Professional Services			674,919	674,919	(288,741)	386,178	(341,980)	44,198		19
20	Dues, Fees, Subscriptions & Promotions			25,950	25,950	17,606	43,556	(9,352)	34,204		20
21	Clerical & General Office Expenses	104,327	5,239	33,929	143,495	96,308	239,803	(82,220)	157,583		21
22	Employee Benefits & Payroll Taxes			688,476	688,476	1,588	690,064	(152,193)	537,871		22
23	Inservice Training & Education			7,111	7,111	1,448	8,559	(1,172)	7,387		23
24	Travel and Seminar			7,097	7,097		7,097	(781)	6,316		24
25	Other Admin. Staff Transportation			5,049	5,049	23,142	28,191	(8,150)	20,041		25
26	Insurance-Prop.Liab.Malpractice			1,259	1,259	5,060	6,319	41,566	47,885		26
27	Other (specify):* Indigent Care			46,794	46,794		46,794	(46,794)			27
28	TOTAL General Administration	252,729	5,239	1,584,736	1,842,704	(19,422)	1,823,282	(643,556)	1,179,726		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,733,693	500,647	1,818,088	6,052,428	(19,412)	6,033,016	(1,202,886)	4,830,130		29

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

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

Facility Name & ID Number

Walter Lawson Childrens Home

#0035469

Report Period Beginning:

07/01/2013

Ending:

6/30/2014

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation					7,679	7,679	147,721	155,400			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			52,061	52,061		52,061	115,882	167,943			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			507,177	507,177	11,376	518,553	(507,177)	11,376			34
35	Rent-Equipment & Vehicles			14,269	14,269	357	14,626	(423)	14,203			35
36	Other (specify):* Mortgage Ins							37,927	37,927			36
37	TOTAL Ownership			573,507	573,507	19,412	592,919	(206,070)	386,849			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	1,119,492	7,001	88,231	1,214,724		1,214,724	(1,203,754)	10,970			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			396,996	396,996		396,996		396,996			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	1,119,492	7,001	485,227	1,611,720		1,611,720	(1,203,754)	407,966			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,853,185	507,648	2,876,822	8,237,655		8,237,655	(2,612,710)	5,624,945			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

Walter Lawson Children's Home

STATE OF ILLINOIS

0035469

Report Period Beginning:

7/1/2013

Ending:

Walter Lawson Children's Home
Schedule V Supplemental Schedule
Reclassifications

DESCRIPTION	INCREASE	DECREASE	SCH V LINE.COL
<u>1 Reclassification of Hoosier Care Group Expenses:</u>			
Administrative (Rel. Party Group Expense Allocation)		(92,011)	17.5
Administration	66,344		17.5
Professional Services	10,482		19.5
Dues, Fees, Subscriptions & Promotions	15,176		20.5
Clerical & General Office Expenses	9		21.5
<u>2 Reclassification of ELC Corporate Expenses</u>			
Professional Services (Rel. Party Mgmt. Fee)		(310,129)	19.5
Maintenance	10		6.5
Administrative	149,834		17.5
Professional Services	10,906		19.5
Dues, Fees, Subscriptions & Promotions	2,430		20.5
Clerical & General Office Expenses	96,299		21.5
Employee Benefits & Payroll Taxes	1,588		22.5
Inservice Training & Education	1,448		23.5
Travel & Seminar	23,142		25.5
Insurance - Prop.Liab.Malpractice	5,060		26.5
Depreciation	7,679		30.5
Rent - Facility & Grounds	11,376		34.5
Rent - Equipment	357		35.5

	Purpose of Seminar	Name of Attendeed	Title of Attendee	Exp Amount
	Relias Learning LLC Core Curriculum Education Software Annual Bill - billing for Jan - June			2,250.00
	Silverchair Learning Systems Core Curriculum Education Software Quarterly Bill - billing for July - September			492.00
	Illinois Alliance of Administrators of Special Education Annual Fall Conference	Katie Johnson	Dietary Asst	175.00
	Illinois Alliance of Administrators of Special Education Annual IAASE Membership	Katie Johnson	Dietary Asst	130.00
	Silverchair Learning Systems Core Curriculum Education Software Quarterly Bill - billing for October - December			492.00
A	Jeff Vose, Sangamon County ROE Illinois State Board of Education Conference	Andrea Moore	Special Education Teacher	135.00
A	AMDA AMDA Conference	John Noffsinger	Director of Marketing	51.75
	Silverchair Learning Systems Core Curriculum Education Software Quarterly Bill - billing for January - March			1,665.51
	AANAC CLASS: Resident Assessment Coding Certification	Yvonne Vandosdol	Regional Director of Clinical Services	9.89
A	Northern Illinois Center for Nonprofit Excellence Leadership Café Registration Fee	Denise Beard	Day Training - Program Director	15.00
	Silverchair Learning Systems Core Curriculum Education Software Quarterly Bill - billing for April - June			1,665.51

A	Illinois State Board of Education Learn-IT 2014 Conference	Andrea Moore	Education - Teachers	29.00
Line 23 Column 4 Total:				<u><u>7,111</u></u>
Line 23 Column 5 Reclassification - Corporate/Home Office Allocated Costs:				1,448
Line 23 Column 6 Total:				<u><u>8,559</u></u>
<i>Unallowable Amounts above removed through SCH 5 Adjustments:</i>				
A	Non-care related amounts noted above:			(231)
	Allocation for non-care-related Education and Day Training (See Pg 11.2 & 5A)			(941)
Line 23 Column 8 Total:				<u><u>7,387</u></u>

Home

Schedule

Facility Name & ID Number Walter Lawson Childrens Home

0035469

Report Period Beginning: 07/01/2013

Ending: 6/30/2014

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs	(1,203,754)	39		3
4	Non-Patient Meals	(59,324)	1		4
5	Telephone, TV & Radio in Resident Rooms	(771)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(260)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(5,049)	25		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(33)	20		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(29)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(46,794)	27		24
25	Fund Raising, Advertising and Promotional	(14,855)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See SCH 5A	(1,061,196)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,392,065)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(220,645)	17, 19	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (220,645)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (2,612,710)		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY					
48		49		50	51
					52

Walter Lawson Childrens Home

ID# 0035469

Report Period Beginning: 07/01/2013

Ending: 6/30/2014

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Contributions Received Offset	\$ (55,582)	21	1
2	Unallowable Depr Exp (below threshold, non-cap)	(32,221)	30	2
3	Unallowable Portion of Inservice Training/Edu	(231)	23	3
4	Unallowable Lobbying Portion of ILHCA Dues	(1,593)	20	4
5	Unallowable Auto Rental Expense	(423)	35	5
6				6
7	Property Taxes Appealed & Not Claimed	(46,756)	33	7
8				8
9	Unallowable Day Trng & Education Alloc - Dietary	(19,573)	1	9
10	Unallowable Day Trng & Education Alloc - Food	(5,919)	2	10
11	Unallowable Day Trng & Education Alloc - Hskpg	(22,532)	3	11
12	Unallowable Day Trng & Education Alloc - Laundry	(10,436)	4	12
13	Unallowable Day Trng & Education Alloc - Heat/Util	(27,647)	5	13
14	Unallowable Day Trng & Education Alloc - Maint	(31,972)	6	14
15	Unallowable Day Trng & Education Alloc - Nursing	(358,794)	10	15
16	Unallowable Day Trng & Education Alloc - Therapy	(14,245)	10a	16
17	Unallowable Day Trng & Education Alloc - Activities	(8,117)	11	17
18				18
19	Unallowable Day Trng & Education Admin Alloc	(40,339)	17	19
20	Unallowable Day Trng & Education Prof Svcs Alloc	(42,480)	19	20
21	Unallowable Day Trng & Education Dues/Fees Alloc	(4,791)	20	21
22	Unallowable Day Trng & Education Clerical Alloc	(26,378)	21	22
23	Unallowable Day Trng & Education EE Ben/PR Tax Allc	(152,193)	22	23
24	Unallowable Day Trng & Education Insrv/Trn Alloc	(941)	23	24
25	Unallowable Day Trng & Education Travel/Seminar Allo	(781)	24	25
26	Unallowable Day Trng & Education Admin Transp Alloc	(3,101)	25	26
27	Unallowable Day Trng & Education Insur Alloc	(695)	26	27
28	Unallowable Day Trng & Education Depr Alloc	(66,009)	30	28
29	Unallowable Day Trng & Education Interest Alloc	(71,337)	32	29
30	Unallowable Day Trng & Education Mortgage Ins Alloc	(16,110)	36	30
31				31
32				32

33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	(1,061,196)	49

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
<u>Hoosier Care, Inc.</u>	<u>100</u>	<u>Exceptional Care & Training Center</u>	<u>Sterling, IL</u>	<u>Medical Rehabilitation</u>	<u>Lexington, KY</u>	<u>Mgmt Co.</u>
		<u>Swann Special Care Center</u>	<u>Champaign, IL</u>	<u>Hoosier Care Investme</u>	<u>Nashville, TN</u>	<u>NFP Affiliated Co.</u>
		<u>Vernon Manor Children's Home</u>	<u>Wabash, IN</u>	<u>Loves Park Facility Co</u>	<u>Loves Park, IL</u>	<u>Property Co.</u>
		<u>Richland-Bean Blossom Health Care Center</u>	<u>Ellettsville, IN</u>			
		<u>Exceptional Living Centers of Brazil</u>	<u>Brazil, IN</u>			
		<u>Randolph Nursing Home</u>	<u>Winchester, IN</u>			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
<u>1</u>	<u>V</u>	<u>17</u>	<u>Corporate Group Overhead</u>	<u>\$ 94,152</u>	<u>Hoosier Care, Inc.</u>	<u>100.00%</u>	<u>\$ 92,011</u>	<u>\$ (2,141)</u>	<u>1</u>
<u>2</u>	<u>V</u>			<u>Note: See Schedule VIII for Allocation of Col. 7 amt and reclassification to functional expense lines on Schedule V.</u>					
<u>3</u>	<u>V</u>								<u>3</u>
<u>4</u>	<u>V</u>								<u>4</u>
<u>5</u>	<u>V</u>	<u>19</u>	<u>Rel. Party Management Fee</u>	<u>609,600</u>	<u>Medical Rehabilitation Centers, LLC</u>	<u>37.50%</u>	<u>310,129</u>	<u>(299,471)</u>	<u>5</u>
<u>6</u>	<u>V</u>			<u>dba Exceptional Living Centers</u>					<u>6</u>
<u>7</u>	<u>V</u>			<u>Hoosier Care owns a beneficial interest in MRC</u>					<u>7</u>
<u>8</u>	<u>V</u>			<u>Note: Please see Schedule VIII for Allocation of Col. 7 amt and reclassification to functional expense lines on Sch V.</u>					
<u>9</u>	<u>V</u>								<u>9</u>
<u>10</u>	<u>V</u>								<u>10</u>
<u>11</u>	<u>V</u>	<u>PLEASE SEE DISCLOSURE AND ADJUSTMENTS CONTINUED ON THE NEXT PAGE (6A):</u>							
<u>12</u>	<u>V</u>								<u>12</u>
<u>13</u>	<u>V</u>								<u>13</u>
<u>14</u>	Total		\$ 703,752				\$ 402,140	\$ * (301,612)	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	34 Rel. Party Bldg/Equip Rent	\$ 507,177	Champaign Facility Company, LLC	100.00%	\$	\$ (507,177)
16	V			This facility company is under 100% common			
17	V			ownership with SSCC, and therefore the "rent" paid			
18	V			to the facility company has been removed from this report,			
19	V			and the actual expenses of the facility company have been			
20	V			added here:			
21	V	30 Actual Depreciation of Rel Pty		-Depreciation		245,951	245,951
22	V	32 Actual Interest of Rel Pty		-Interest (net of interest income)		180,522	180,522
23	V	32 Actual Amort of Debt Cost-Rel Pty		-Amort of Debt Costs		6,697	6,697
24	V	26 Actual Insurance of Rel Pty		-Insurance		42,261	42,261
25	V	36 Actual Mortgage Ins of Rel Pty		-Mortgage Insurance		54,037	54,037
26	V	20 Actual Accting Fees of Rel Pty		-Accounting Fees		11,920	11,920
27	V	33 Actual Real Estate Taxes of Rel Pty		-Property Taxes (disputed and removed via SCH V adjustment)		46,756	46,756
28	V						
29	V						
30	V	32 Rel Party Interest/Bldg Financing	52,061	Hoosier Care Investments, LLC	100.00%	52,061	
31	V			This related party, under common control with Hoosier Care,			
32	V			Inc., provided a loan in 2007 to WLCH to finance a building			
33	V			addition. The actual interest expense represents the related			
34	V			party's actual cost of capital, reflecting the interest rate			
35	V			environment at the time of financing, and the fully-subordinated,			
36	V			unsecured nature of the debt, junior to all other obligations of WLCH.			
37	V						
38	V						
39	Total		\$ 559,238			\$ 640,205	\$ * 80,967

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

Facility Name & ID Number Walter Lawson Childrens Home # 0035469 Report Period Beginning: 07/01/2013 Ending: 6/30/2014

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	John Foos	Board Member	Governance	0%					\$	1	
2	John Gillmor	Board Member	Governance	0%						2	
3	Bruce Hutson	Board Member	Governance	0%						3	
4	Jo Anne Corbitt	Board Member	Governance	0%						4	
5	Douglas Smith	Board Member	Governance	0%						5	
6	Stephen Wood	Board Member	Governance	0%						6	
7	NOTE: Fees are paid by WLCH (through the Hoosier Care, Inc. group/home cost center detailed on Pg 8) to Hoosier Care Investments, LLC ("HCI"; an affiliated not-for-profit									7	
8	which go toward, among other things solely within the control of HCI, fees for members of the Boards of Directors of HCI affiliated facilities, Walter Lawson									8	
9	Children's Home being one of many. Therefore no Board Fees or compensation are paid directly by, or known to WLCH, but rather the fees paid by HoosierCare to HCI									9	
10	combined with similar fees paid by other facilities, for HCI to provide governance and managerial oversight, including payment by HCI to Board members of each legal									10	
11	entity. Fees paid by other facilities, if known, are shown on Page 7.1; The entire amount of fees included on this report, grouped on Line 17, is disclosed here:									11	
12								ADMIN FEES	66,344	17.8	12
13								TOTAL	\$ 66,344		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

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

*** 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.**

Amounts paid for Home Office Administration Fees by other Nursing Homes

Walter Lawson Children's Home	66,344	Illinois
Swann Special Care Center	79,617	Illinois
Exceptional Care & Training Center	48,668	Illinois
Vernon Manor Children's Home	45,363	Indiana
Exceptional Living Center of Brazil	56,710	Indiana
Richland-Bean Blossom Health Care	48,168	Indiana
Randolph Nursing Home	41,545	Indiana

Net allowable Related Party Management Fees paid by other Nursing Homes

Walter Lawson Children's Home	310,130	Illinois
Swann Special Care Center	372,177	Illinois
Exceptional Care & Training Center	227,501	Illinois
Vernon Manor Children's Home	212,053	Indiana
Exceptional Living Center of Brazil	265,096	Indiana
Richland-Bean Blossom Health Care	225,165	Indiana
Randolph Nursing Home	194,205	Indiana

Facility Name & ID Number Walter Lawson Childrens Home

0035469 Report Period Beginning: 07/01/2013

Ending: 7/30/2014

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

Name of Related Organization Hoosier Care, Inc.
 Street Address 1050 Chinoe Road, Suite 350
 City / State / Zip Code Lexington, KY 40502
 Phone Number (859) 255-0075
 Fax Number (859) 281-5150

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	Administrative	Direct Cost	40,915,656	7	\$ 386,413	\$ 386,413	7,024,836	\$ 66,344	1
2	19	Professional Services	Direct Cost	40,915,656	7	61,051	61,051	7,024,836	10,482	2
3	20	Dues, Fees, Subscriptions & Prom	Direct Cost	40,915,656	7	88,392	88,392	7,024,836	15,176	3
4	21	Clerical & General Office Expens	Direct Cost	40,915,656	7	53	53	7,024,836	9	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					\$ 535,909	\$ 535,909		\$ 92,011	25

Facility Name & ID Number Walter Lawson Children's Home

0035469 Report Period Beginning: 7/1/2013

Ending: 06/30/2014

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

Name of Related Organization Medical Rehabilitation Centers, LLC, db
 Street Address 1050 Chinoe Road, Suite 350
 City / State / Zip Code Lexington, KY 40502
 Phone Number (859) 255-0075
 Fax Number (859) 281-5150

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

1	2	3	4	5	6	7	8	9
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6
1	6	Maintenance	Direct Costs	15	\$ 120	\$	7,024,836	\$ 10
2	17	Administrative	Direct Costs	15	1,739,864	1,739,864	7,024,836	149,834
3	19	Professional Services	Direct Costs	15	126,640		7,024,836	10,906
4	20	Dues, Fees, Subscriptions	Direct Costs	15	28,212		7,024,836	2,430
5	21	Clerical & General Office	Direct Costs	15	1,118,216	944,495	7,024,836	96,299
6	22	Employee Benefits & Payroll Tax	Direct Costs	15	18,436		7,024,836	1,588
7	23	Inservice Training & Education	Direct Costs	15	16,818		7,024,836	1,448
8	25	Travel & Seminar	Direct Costs	15	268,725		7,024,836	23,142
9	26	Insurance	Direct Costs	15	58,760		7,024,836	5,060
10	30	Depreciation	Direct Costs	15	89,168		7,024,836	7,679
11	32	Interest	Direct Costs	15	0		7,024,836	0
12	34	Rent - Facility & Grounds	Direct Costs	15	132,093		7,024,836	11,376
13	35	Rent - Equipment	Direct Costs	15	4,150		7,024,836	357
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25	TOTALS				\$ 3,601,202	\$ 2,684,359		\$ 310,129

a Exceptional Living Centers

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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	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
A. Directly Facility Related																	
Long-Term																	
1	Hoosier Care Investments, LLC	X		Addition to Facility	\$25,493.00	03/15/07	\$ 3,000,000	\$ 527,705	04/15/27	0.0800	\$ 52,061						
2	LP Mortgage HUD Loan 2012		X	Purchase of Facility Refi	\$28,956.00	11/01/12	7,290,000	6,871,527	11/01/42	0.0254	180,815						
3																	
4																	
5																	
Working Capital																	
6	GE Healthcare Finance		X	Working Capital		10/27/11	5,000,000		10/27/14	Varies							
7																	
8																	
9	TOTAL Facility Related				\$54,449.00		\$ 15,290,000	\$ 7,399,232			\$ 232,876						
B. Non-Facility Related*																	
10																	
11																	
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$			\$						
15	TOTALS (line 9+line14)						\$ 15,290,000	\$ 7,399,232			\$ 232,876						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 54,037 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.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)**B. Real Estate Taxes**

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2013 report.			\$	1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2	
3. Under or (over) accrual (line 2 minus line 1).			\$	3	
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2009 _____	8	FOR BHF USE ONLY		
	2010 _____	9			
	2011 _____	10			
	2012 _____	11			
	2013 _____	12			
Note: This facility became exempt from Property Taxes starting on 1/1/1996.			13	FROM R. E. TAX STATEMENT FOR 2013 \$	13
Currently, a dispute and appeal regarding the status of this exemption is ongoing, and WLCH expects to prevail and thus maintain its tax exempt status. Although payment of taxes was made in order to avoid potential assessment of interest and penalties, a full refund is expected and no costs are claimed on this cost report. See SCH 5A for adjustment of amt			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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Walter Lawson Childrens Home COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0035469

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2013 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 2013.

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

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Walter Lawson Education Program, operated within dedicated space of building; Adjustments & allocation to remove associated costs shown on SCH V, further explanation Pg 23.

Walter Lawson Developmental Day Training Program, operated within dedicated space of building; Adjustments & allocation to remove associated costs shown on SCH V, further explanation Pg 23.

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

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

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	Accumulated Depreciation
4	93	1989	1971	\$ 2,917,000	\$ 63,425	40	\$ 63,425	\$ 1,960,340
5	6		2008	3,659,316	91,482	40	91,482	571,768
6								
7								
8								
Improvement Type**								
9	CARRIER HEAT/AIR CONDITIO	1/11/1990		17,400.00	-	5-0		17,400.00
10	REMODEL LAUNDRY ROOM	2/1/1994		3,153.98	-	10-0		3,153.98
11	A/C ROOFTOP UNIT	7/1/1994		8,985.00	-	10-0		8,985.00
12	INSTALL NEW WINDOWS	12/20/1995		2,587.50	-	10-0		2,587.50
13	TILE KITCHEN FLOOR	1/31/1996		5,187.00	-	10-0		5,187.00
14	INSTALL WATER HEATER	3/19/1996		4,981.25	-	10-0		4,981.25
15	INSTALL WATER HEATER	2/11/1997		6,014.21	-	10-0		6,014.21
16	SHOWER TROLLEY	3/11/1997		10,923.53	-	10-0		10,923.53
17	RE-ROOF NORTH WING, GRAVEL	6/18/1997		27,596.00	-	10-0		27,596.00
18	INSTALL A/C ROOF-TOP UNIT	7/16/1997		2,975.00	-	10-0		2,975.00
19	INSTALL EMERGENCY GENERAT	1/12/1998		85,329.00	-	10-0		85,329.00
20	NEW ROOF TOP HVAC UNIT	1/19/1999		4,340.00	-	10-0		4,340.00
21	TEAR OFF AND REPLACE ROOF	7/30/1999		2,500.00	125.00	20-0	125	1,875.16
22	INSTALL NEW ROOF SHINGLES	11/1/1999		3,727.00	186.35	20-0	186	2,733.17
23	INSTALL	11/29/1999		3,265.00	217.67	15-0	218	3,192.53
24	PARTIAL PMT-TELEPHONE SYS	3/27/2000		3,264.02	-	10-0		3,264.02
25	PARTIAL PMT-TELEPHONE SYS	3/27/2000		6,528.04	-	10-0		6,528.04
26	FIRE SPRINKLER SYSTEM.	1/15/2001		37,774.00	1,510.96	25-0	1,511	20,397.86
27	DURO-LAST ROOF SYSTEM.	5/15/2001		40,846.00	1,633.84	25-0	1,634	21,512.14
28	DONATION OF NURSE	10/1/2001		6,594.00	439.60	15-0	440	5,604.83
29	BOOSTER PUMP	12/31/2001		4,837.00	322.47	15-0	322	4,057.70
30	NEW HEAT EXCHANGER,INDUCE	9/20/2002		2,818.15	187.88	15-0	188	2,223.28
31	REMODELING PROJECT	6/30/2003		3,540.80	-	10-0		3,540.80
32	New flooring in 2 rooms	4/10/2004		2,576.00	-	7-0		2,576.00
33	therapy room/spa	11/30/2004		198,856.36	7,954.25	25-0	7,954	76,228.23
34	Water heater (75 gallon)	6/30/2006		6,375.89	637.59	10-0	638	5,100.72
35	HVAC unit for B wing	12/19/2006		7,600.00	760.00	10-0	760	5,700.00
36	Rooftop hvac unit	4/24/2008		3,973.00	397.30	10-0	397	2,450.02

*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

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	10
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Induct air purifiers (12)	12/7/2009	\$ 3,911.91	\$ 391.19	10-0	\$ 391	\$	\$ 1,792.95	37
38	A.O. Smith water heater	8/17/2010	7,018.87	701.89	10-0	702		2,690.58	38
39	Sentronic door closers (2) for old bldg	6/23/2011	3,025.00	302.50	10-0	303		907.50	39
40	Remodel C wing bathing room	12/16/2011	10,848.33	723.22	15-0	723		1,808.05	40
41	Rpl roof and ceiling in maintenance shed	1/20/2012	5,450.00	545.00	10-0	545		1,317.08	41
42	Kitchen & dining room remodeling	3/9/2012	19,090.40	1,272.69	15-0	1,273		2,969.61	42
43	West side siding, maint. shop drywall	4/18/2012	4,929.00	492.90	10-0	493		1,067.95	43
44	Exterior lights, interior recep, exit li	7/20/2012	3,304.38	330.44	10-0	330		633.34	44
45	Roof top units (2)	11/19/2012	12,680.00	1,268.00	10-0	1,268		2,007.67	45
46	BLACKTOP DRIVEWAY	11/24/1993	10,130.00	-	10-0			10,130.00	46
47	STRIP/SEAL NORTH PARKING	9/25/1995	3,382.00	-	10-0			3,382.00	47
48	PARKING LOT	9/22/1997	9,898.00	-	10-0			9,898.00	48
49	FENCE ON BACK LOT	10/7/1997	5,680.00	-	10-0			5,680.00	49
50	BLACKTOP NEW PARKING,DRIV	7/9/1998	9,752.00	-	10-0			9,752.00	50
51	REPLACE CONCRETE AT PAVIL	9/15/2000	2,700.00	180.00	15-0	180		2,490.00	51
52	Drywell	11/12/2008	12,588.00	629.40	20-0	629		3,566.60	52
53	Concrete gazebo floor & walks	5/11/2012	10,120.50	1,012.05	10-0	1,012		2,192.78	53
54	2 F2900 Controllers and Resin	2/25/2004	5,880.00	-	7-0			5,880.00	54
55	INSTALL SUMP PUMP & MANHO	10/19/1994	3,200.00	-	10-0			3,200.00	55
56	WATER BOOSTER SYS REPLACE	1/30/1995	6,941.00	-	10-0			6,941.00	56
57	INSTALL NEW MIXING VALVE	4/26/1996	2,960.00	-	10-0			2,960.00	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)		\$ 7,244,353	\$ 177,129		\$ 177,129	\$	\$ 2,959,832	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	\$ 150,693	\$ 26,864	\$ 26,864	\$	3-10	\$ 105,641	71
72	Current Year Purchases	6,413	1,603	1,603		3-7	1,603	72
73	Fully Depreciated Assets	524,390				3-10	524,390	73
74	<u>Depr Exp - Rel Pty Alloc Sch VIII</u>		7,679	7,679				74
75	TOTALS	\$ 681,496	\$ 36,146	\$ 36,146	\$		\$ 631,634	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	<u>Patient Transportation</u>	<u>2012 Ford E250 Van w/ Lift</u>	<u>2012</u>	\$ 40,670	\$ 8,134	\$ 8,134	\$	5	\$ 16,946	76
77										77
78										78
79										79
80	TOTALS			\$ 40,670	\$ 8,134	\$ 8,134	\$		\$ 16,946	80

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)	\$ 8,650,947	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 221,409	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 221,409	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,608,412	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	<u>Transportation Equip Not Allowed</u>	\$ 55,688	\$	\$ 55,688	86
87	<u>Assets below IL Capital Threshold</u>	381,246	17,925	329,236	87
88	<u>Other Assets Disallowed</u>	285,913	14,296	238,261	88
89					89
90					90
91	TOTALS	\$ 722,847	\$ 32,221	\$ 623,185	91

G. Construction-in-Progress

	Description	Cost	
92	<u>IT Systems Progress</u>	\$ 5,122	92
93	<u>Bath/Plumbing Work in Prog</u>	6,642	93
94			94
95		\$ 11,764	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 Walter Lawson Childrens Home

0035469

Report Period Beginning: 07/01/2013

Ending: 6/30/2014

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	11,376	10	10	6
7	TOTAL				\$ 11,376			7

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. 6/30/2015 \$ Corp Alloc Amt

13. 6/30/2016 \$ Corp Alloc Amt

14. 6/30/2017 \$ Corp Alloc Amt

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: \$ 14,203 Description: Postage Meter: \$350; Short Term Medical Equip: \$13,496; Corp Alloc: \$357

(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

* 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 Walter Lawson Childrens Home # 0035469 Report Period Beginning: 07/01/2013 Ending: 6/30/2014
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			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		584	40,845						584		40,845		2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	10a.1	2141 hrs	78,077								2,141		78,077		4
5	Physician Care		visits													5
6	Dental Care	39.3	visits		89	4,416						89		4,416		6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy		# of prescrpts													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			\$ 78,077	673	\$ 45,261		\$				2,814	\$	123,338		14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Walter Lawson Childrens Home# 0035469Report Period Beginning: 07/01/2013

Ending:

6/30/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2014

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 300	\$ 19,410	1
2	Cash-Patient Deposits	96,804	96,804	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>62,813</u>)	1,353,733	1,353,733	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	109,406	138,876	6
7	Other Prepaid Expenses	4,424	4,424	7
8	Accounts Receivable (owners or related parties)	4,075,332	4,075,332	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,639,999	\$ 5,688,579	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		7,656,147	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost		1,033,220	16
17	Accumulated Depreciation (book methods)		(4,231,598)	17
18	Deferred Charges		189,884	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		338,960	21
22	Other Long-Term Assets (spec CIP)		11,764	22
23	Other(specify): <u>Goodwill</u>	261,131	261,131	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 261,131	\$ 5,943,936	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,901,130	\$ 11,632,515	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 206,401	\$ 206,678	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	96,804	96,804	28
29	Short-Term Notes Payable	273,590	444,171	29
30	Accrued Salaries Payable	428,118	428,118	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,000	9,000	31
32	Accrued Real Estate Taxes(Sch.IX-B)		19,095	32
33	Accrued Interest Payable	2,580	17,486	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Intercompany payables</u>	77,742	118,250	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,094,235	\$ 1,339,602	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	254,115	7,125,642	39
40	Mortgage Payable			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)	\$ 254,115	\$ 7,125,642	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,348,350	\$ 8,465,244	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,552,780	\$ 3,167,271	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,901,130	\$ 11,632,515	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,817,310	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,817,310	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	735,470	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)	\$ 735,470	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)	\$ 4,552,780	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,774,484	1
2	Discounts and Allowances for all Levels	179	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,774,663	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	1,312,142	9
10	Other Government Grants	59,324	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,371,466	23
D. Non-Operating Revenue			
24	Contributions	55,582	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 55,582	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Day Training Revenue	771,414	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 771,414	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,973,125	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	731,418	31
32	Health Care	3,478,306	32
33	General Administration	1,842,704	33
B. Capital Expense			
34	Ownership	573,507	34
C. Ancillary Expense			
35	Special Cost Centers	1,214,724	35
36	Provider Participation Fee	396,996	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,237,655	40
41	Income before Income Taxes (line 30 minus line 40)**	735,470	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 735,470	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 6,774,663	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)	\$ 6,774,663	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.

Facility Name & ID Number Walter Lawson Childrens Home

0035469

Report Period Beginning: 07/01/2013

Ending: 6/30/2014

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,083	2,372	\$ 112,376	\$ 47.38	1
2	Assistant Director of Nursing					2
3	Registered Nurses	18,606	20,373	627,287	30.79	3
4	Licensed Practical Nurses	20,083	22,417	692,681	30.90	4
5	CNAs & Orderlies	109,708	119,456	1,410,619	11.81	5
6	CNA Trainees					6
7	Licensed Therapist	1,949	2,141	78,077	36.47	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,842	2,083	33,133	15.91	9
10	Activity Assistants	4,305	4,568	40,332	8.83	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,887	2,004	37,349	18.64	13
14	Head Cook	7,789	8,465	99,885	11.80	14
15	Cook Helpers/Assistants	1,053	1,132	10,223	9.03	15
16	Dishwashers					16
17	Maintenance Workers	3,712	3,938	55,963	14.21	17
18	Housekeepers	13,305	14,650	193,493	13.21	18
19	Laundry	8,501	9,204	89,546	9.73	19
20	Administrator	2,517	2,852	148,402	52.03	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,907	4,302	104,327	24.25	24
25	Vocational Instruction	18,346	20,205	291,800	14.44	25
26	Academic Instruction	35,105	37,848	755,067	19.95	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	3,759	4,159	72,625	17.46	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)	258,457	282,169	\$ 4,853,185 *	\$ 17.20	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	615	\$ 22,584	1, 3	35
36	Medical Director	N/A	13,250	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant	437	18,792	10, 3	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					48
49	TOTAL (lines 35 - 48)	1,052	\$ 54,626		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Melissa Thornbloom	Executive Director	0	\$ 148,402	Workers' Compensation Insurance	\$ 43,737	IDPH License Fee	\$	
				Unemployment Compensation Insurance	162,851	Advertising: Employee Recruitment	1,305	
				FICA Taxes	105,093	Health Care Worker Background Check		
				Employee Health Insurance	373,372	(Indicate # of checks performed <u>95</u>)	4,123	
				Employee Meals				
				Illinois Municipal Retirement Fund (IMRF)*		Public Relations/Mkting/FundRsing	14,855	
				Retirement Plan Matching Contributions	3,423	Illinois Healthcare Association	4,278	
				Corporate/Group Allocation	1,588	Other Dues, Fees, Subscriptions	1,389	
				Less Pg 5A Adj for unallowable EDU/DT portion	(152,193)	Corporate/Group Allocation	29,526	
						Less: Unallowable Fees/Penalties/Dues	(6,417)	
						Less: Public Relations Expense	(14,855)	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						TOTAL (agree to Sch. V, line 20, col. 8)		
					\$ 537,871	\$ 34,204		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description				Description			Description	
Amount				Line #			Amount	
Corporate/Group Admin Allocation							Out-of-State Travel	
\$ 94,152							\$	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			In-State Travel	
\$ 94,152							See Page 21.1 for Detail	
							7,097	
							Seminar Expense	
							SCH 5 Adj - DT/EDU Alloc	
							(781)	
							Entertainment Expense	
							()	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)							TOTAL (agree to Sch. V, line 24, col. 8)	
\$ 674,919							\$ 6,316	

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number

Walter Lawson Children's Home # 0035469 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

Walter Lawson Children's Home
Schedule XIX Supplemental Schedule
Legal Fees Detail

DATE	DESCRIPTION	Amount
1 Legal Fees detail for SCH XIX-C		
8/19/2013	SmithAmundsen	\$ 1,695
9/16/2013	SmithAmundsen	\$ 3,243
9/23/2013	Duane Morris LLP	\$ 42
10/8/2013	Bradley Arant Boulton Cummings LLP	\$ 466
10/15/2013	Duane Morris LLP	\$ 21
10/15/2013	SmithAmundsen	\$ 640
11/5/2013	Bradley Arant Boulton Cummings LLP	\$ 437
11/19/2013	SmithAmundsen	\$ 2,501
11/30/2013	Bradley Arant Boulton Cummings LLP	\$ 1,726
12/31/2013	jb-rcl ap 53141 GE portion	\$ (129)
12/31/2013	jb-rcls ap 58824 GE portion	\$ (1,287)
1/20/2014	SmithAmundsen	\$ 125
1/30/2014	Duane Morris LLP	\$ 21
2/18/2014	SmithAmundsen	\$ 1,750
4/18/2014	SmithAmundsen	\$ 825
4/28/2014	Baker, Donelson, Bearman, Caldwell & Berkowitz, PC	\$ 299
5/26/2014	SmithAmundsen	\$ 1,853
6/23/2014	SmithAmundsen	\$ 1,311
6/30/2014	6.14 Accrued Expenses #2	\$ 1,288
6/30/2014	6.14 Accrued Expenses #2	\$ 731
7/28/2013	In-House Counsel Legal Fees	\$ 1,350
8/31/2013	In-House Counsel Legal Fees	\$ 544
9/30/2013	In-House Counsel Legal Fees	\$ 1,003
10/31/2013	In-House Counsel Legal Fees	\$ 912
11/30/2013	In-House Counsel Legal Fees	\$ 948
12/31/2013	In-House Counsel Legal Fees	\$ 1,327
12/31/2013	In-House Counsel Legal Fees	\$ (73)
1/31/2014	In-House Counsel Legal Fees	\$ 1,035
2/28/2014	In-House Counsel Legal Fees	\$ 786
3/31/2014	In-House Counsel Legal Fees	\$ 1,039

4/30/2014	In-House Counsel Legal Fees	\$	990
5/31/2014	In-House Counsel Legal Fees	\$	913
6/30/2014	In-House Counsel Legal Fees	\$	506
6/30/2014	In-House Counsel Legal Fees	\$	430
8/16/2013	Bradley Arant Boult Cummings LLP	\$	30
12/17/2013	DeWitt Ross & Stevens	\$	55
12/27/2013	Taft Stettinius & Hollister LLP	\$	29
		<u>\$</u>	<u>29,382</u>

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	None	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Walter Lawson Childrens Home# 0035469Report Period Beginning: 07/01/2013Ending: 6/30/2014**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, \$2,685 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? 5 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 84,441 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 No 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. \$ 396,996
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 23.2 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 benefits on Schedule V. \$ _____ Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation. Alloc of Home Office Personnel Travel
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.

Walter Lawson Children's Home
 Schedule XX Supplemental Schedule
 Item 14 - Allocation of non-long term care costs

(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 23.2 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.

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 administrative, overhead, and support services. Square footage dedicated to each operation is utilized to allocate depreciation, interest, and other capital items.

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

	SNF	DT	EDU
% of Salaries for alloc of EE Benefits/PR Taxes	65%	25%	10%
% of total program hours operated for other items	89%	5%	6%
% of S/F for Capital/building/occupancy	70%	6%	24%