

Facility Name & ID Number Walter Lawson Childrens Home

0035469 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED	35,339			35,339
10	ICF				10
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	35,339			35,339

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.80%

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

100 (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: FYE 6/30/2015 Fiscal Year: FYE 6/30/2015

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

Facility Name & ID Number

Walter Lawson Childrens Home

0035469

Report Period Beginning:

07/01/2014

Ending:

06/30/2015

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	141,557	6,679	22,474	170,710		170,710	(63,660)	107,050		1
2	Food Purchase		193,709		193,709		193,709	(72,236)	121,473		2
3	Housekeeping	191,198	16,499		207,697		207,697	(99,455)	108,242		3
4	Laundry	80,845	7,063	361	88,269		88,269	(888)	87,381		4
5	Heat and Other Utilities			86,193	86,193		86,193	(41,273)	44,920		5
6	Maintenance	53,236	10,011	52,120	115,367	414	115,781	(55,441)	60,340		6
7	Other (specify):*										7
8	TOTAL General Services	466,836	233,961	161,148	861,945	414	862,359	(332,953)	529,406		8
	B. Health Care and Programs										
9	Medical Director			13,750	13,750		13,750		13,750		9
10	Nursing and Medical Records	2,786,831	253,520	16,897	3,057,248		3,057,248	(74,175)	2,983,073		10
10a	Therapy	76,714	11,645	37,905	126,264		126,264	(40,547)	85,717		10a
11	Activities	79,213	305		79,518		79,518		79,518		11
12	Social Services										12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,942,758	265,470	68,552	3,276,780		3,276,780	(114,722)	3,162,058		16
	C. General Administration										
17	Administrative	120,668		123,121	243,789	225,431	469,220	(109,110)	360,110		17
18	Directors Fees										18
19	Professional Services			676,437	676,437	(371,334)	305,103	(236,519)	68,584		19
20	Dues, Fees, Subscriptions & Promotions			39,421	39,421	23,065	62,486	(32,235)	30,251		20
21	Clerical & General Office Expenses	97,977	7,201	42,772	147,950	22,350	170,300	(144,569)	25,731		21
22	Employee Benefits & Payroll Taxes			712,483	712,483	38,946	751,429	(132,296)	619,133		22
23	Inservice Training & Education			14,549	14,549	952	15,501	(5,168)	10,333		23
24	Travel and Seminar			4,479	4,479	33,097	37,576	(4,771)	32,805		24
25	Other Admin. Staff Transportation			137	137		137	(75)	62		25
26	Insurance-Prop.Liab.Malpractice			18,472	18,472	3,644	22,116	19,053	41,169		26
27	Other (specify):* Indigent Care			(16,527)	(16,527)		(16,527)	16,527			27
28	TOTAL General Administration	218,645	7,201	1,615,344	1,841,190	(23,849)	1,817,341	(629,164)	1,188,177		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,628,239	506,632	1,845,044	5,979,915	(23,435)	5,956,480	(1,076,839)	4,879,641		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:

07/01/2014

Ending:

06/30/2015

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					6,643	6,643	93,914	100,557			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			30,992	30,992	4,541	35,533	96,166	131,699			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			546,248	546,248	11,548	557,796	(551,778)	6,018			34
35	Rent-Equipment & Vehicles			6,916	6,916	703	7,619	(337)	7,282			35
36	Other (specify):*							18,109	18,109			36
37	TOTAL Ownership			584,156	584,156	23,435	607,591	(343,926)	263,665			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	1,011,770	3,910	80,182	1,095,862		1,095,862	(1,095,862)				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			403,672	403,672		403,672		403,672			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	1,011,770	3,910	483,854	1,499,534		1,499,534	(1,095,862)	403,672			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,640,009	510,542	2,913,054	8,063,605		8,063,605	(2,516,627)	5,546,978			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 Childrens Home

STATE OF ILLINOIS

#0035469

Report Period Beginning:

07/01/2014

Ending:

Walter Lawson Childrens 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 Allocatior	(103,067)	17.5
Administration	77,783	17.5
Dues, Fees, Subscriptions & Promotions	20,690	20.5
Clerical & General Office Expenses	53	21.5
Interest	4,541	32.5
<u>2 Reclassification of ELC Corporate Expenses</u>		
Professional Services (Rel. Party Mgmt. Fee)	(389,884)	19.5
Maintenance	414	6.5
Administrative	250,715	17.5
Professional Services	18,550	19.5
Dues, Fees, Subscriptions & Promotions	2,375	20.5
Clerical & General Office Expenses	22,297	21.5
Employee Benefits & Payroll Taxes	38,946	22.5
Inservice Training & Education	952	23.5
Travel & Seminar	33,097	24.5
Insurance - Prop.Liab.Malpractice	3,644	26.5
Depreciation	6,643	30.5
Rent - Facility & Grounds	11,548	34.5
Rent - Equipment	703	35.5

A	ACT Workkeys Applied Math Assessment; Reading for Information; Business Writing	Donna Ploum	Education - Teachers	50
	American Red Cross Adult and Pediatric First Aid/CPR	Various Employees		556
	Silverchair Learning Systems Core Curriculum Education Software Quarterly Bill - billing for Jan - Mar			2,917
	IL Health Care Association ID/DD Symposium 2015	Melissa Thornbloom	Executive Director	125
	Silverchair Learning Systems Core Curriculum Education Software Quarterly Bill - billing for April - June			2,918
	American Red Cross Adult and Pediatric CPR Review	Various Employees		285
A	American Red Cross Adult and Pediatric CPR Review	Various Employees	Education - Teachers	114
A	Allocated Regional Support Costs			91
	Line 23 Column 4 Total:			14,550
	Line 23 Column 5 Reclassification - Corporate/Home Office Allocated Costs:			952
	Line 23 Column 6 Total:			15,502
	<i>Unallowable Amounts above removed through SCH 5 Adjustments:</i>			
A	Non-care related amounts noted above:			(852)
	Allocation for non-care-related Education and Day Training (See Pg 11.2 & 5A)			(4,316)
	Line 23 Column 8 Total:			10,333

Facility Name & ID Number Walter Lawson Childrens Home

0035469

Report Period Beginning: 07/01/2014

Ending: 06/30/2015

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	(1,095,862)	39		3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(20)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,791)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	16,527	27		24
25	Fund Raising, Advertising and Promotional	(16,262)	20		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,123,076)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,220,484)		\$	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)	(296,143)	17, 19	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (296,143)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (2,516,627)		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		X			45
46	Other-Attach Schedule		X			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:	07/01/2014
Ending:	06/30/2015

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Contributions Received Offset	\$ (95,825)	21	1
2	Unallowable Depr Exp (below threshold, non-cap)	(32,516)	30	2
3	Unallowable Portion of Inservice Training/Edu	(852)	23	3
4	Unallowable Lobbying Portion of ILHCA Dues	(2,418)	20	4
5	Unallowable Portion of Travel/Seminar	(274)	24	5
6	Misc Income Offset	(597)	21	6
7				7
8				8
9				9
10	Unallowable Day Trng & EDU Alloc - Dietary	(63,660)	1	10
11	Unallowable Day Trng & EDU Alloc - Food	(72,236)	2	11
12	Unallowable Day Trng & EDU Alloc - Hskpg	(99,455)	3	12
13	Unallowable Day Trng & EDU Alloc - Laundry	(888)	4	13
14	Unallowable Day Trng & EDU Alloc - Heat/Util	(41,273)	5	14
15	Unallowable Day Trng & EDU Alloc - Maint	(55,441)	6	15
16	Unallowable Day Trng & EDU Alloc - Nursing	(74,175)	10	16
17	Unallowable Day Trng & EDU Alloc - Therapy	(40,547)	10a	17
18	Unallowable Day Trng & EDU Alloc - Admin	(89,056)	17	18
19	Unallowable Day Trng & EDU Alloc - Prof Svcs	(8,905)	19	19
20	Unallowable Day Trng & EDU Alloc - Dues/Fees	(13,555)	20	20
21	Unallowable Day Trng & EDU Alloc - Clerical	(48,147)	21	21
22	Unallowable Day Trng & EDU Alloc - EE Ben/PR Tax	(132,296)	22	22
23	Unallowable Day Trng & EDU Alloc - Insrv/Training	(4,316)	23	23
24	Unallowable Day Trng & EDU Alloc - Travel/Seminar	(4,497)	24	24
25	Unallowable Day Trng & EDU Alloc - Admin Trans	(75)	25	25
26	Unallowable Day Trng & EDU Alloc - Insur	(10,590)	26	26
27	Unallowable Day Trng & EDU Alloc - Depr	(122,270)	30	27
28	Unallowable Day Trng & EDU Alloc - Interest	(86,705)	32	28
29	Unallowable Day Trng & EDU Alloc - Bldg Rent	(5,530)	34	29
30	Unallowable Day Trng & EDU Alloc - Bldg Rent	(337)	35	30
31	Unallowable Day Trng & EDU Alloc - Mortgage Ins	(16,639)	36	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	(1,123,076)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Walter Lawson Childrens Home# 0035469

Report Period Beginning:

07/01/2014

Ending:

06/30/2015

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	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(63,660)	0	0	0	0	0	0	0	0	0	0	(63,660)	1
2	Food Purchase	(72,236)	0	0	0	0	0	0	0	0	0	0	(72,236)	2
3	Housekeeping	(99,455)	0	0	0	0	0	0	0	0	0	0	(99,455)	3
4	Laundry	(888)	0	0	0	0	0	0	0	0	0	0	(888)	4
5	Heat and Other Utilities	(41,273)	0	0	0	0	0	0	0	0	0	0	(41,273)	5
6	Maintenance	(55,441)	0	0	0	0	0	0	0	0	0	0	(55,441)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(332,953)	0	0	0	0	0	0	0	0	0	0	(332,953)	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	(74,175)	0	0	0	0	0	0	0	0	0	0	(74,175)	10
10a	Therapy	(40,547)	0	0	0	0	0	0	0	0	0	0	(40,547)	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	(114,722)	0	0	0	0	0	0	0	0	0	0	(114,722)	16
	C. General Administration													
17	Administrative	(89,056)	(20,054)	0	0	0	0	0	0	0	0	0	(109,110)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(10,696)	(237,716)	11,893	0	0	0	0	0	0	0	0	(236,519)	19
20	Fees, Subscriptions & Promotions	(32,235)	0	0	0	0	0	0	0	0	0	0	(32,235)	20
21	Clerical & General Office Expenses	(144,569)	0	0	0	0	0	0	0	0	0	0	(144,569)	21
22	Employee Benefits & Payroll Taxes	(132,296)	0	0	0	0	0	0	0	0	0	0	(132,296)	22
23	Inservice Training & Education	(5,168)	0	0	0	0	0	0	0	0	0	0	(5,168)	23
24	Travel and Seminar	(4,771)	0	0	0	0	0	0	0	0	0	0	(4,771)	24
25	Other Admin. Staff Transportation	(75)	0	0	0	0	0	0	0	0	0	0	(75)	25
26	Insurance-Prop.Liab.Malpractice	(10,590)	0	29,643	0	0	0	0	0	0	0	0	19,053	26
27	Other (specify):*	16,527	0	0	0	0	0	0	0	0	0	0	16,527	27
28	TOTAL General Administration	(412,930)	(257,770)	41,536	0	(629,164)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(860,605)	(257,770)	41,536	0	(1,076,839)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Walter Lawson Childrens Home# 0035469

Report Period Beginning:

07/01/2014 Ending:06/30/2015

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(154,786)	0	248,700	0	0	0	0	0	0	0	0	93,914	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(86,725)	0	182,891	0	0	0	0	0	0	0	0	96,166	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(5,530)	0	(546,248)	0	0	0	0	0	0	0	0	(551,778)	34
35	Rent-Equipment & Vehicles	(337)	0	0	0	0	0	0	0	0	0	0	(337)	35
36	Other (specify):*	(16,639)	0	34,748	0	0	0	0	0	0	0	0	18,109	36
37	TOTAL Ownership	(264,017)	0	(79,909)	0	(343,926)	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	(1,095,862)	0	0	0	0	0	0	0	0	0	0	(1,095,862)	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	(1,095,862)	0	0	0	0	0	0	0	0	0	0	(1,095,862)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(2,220,484)	(257,770)	(38,373)	0	0	0	0	0	0	0	0	(2,516,627)	45

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
Hoosier Care, Inc.	100	Exceptional Care & Training Center	Sterling, IL	Medical Rehabilitation	Lexington, KY	Mgmt Co.
		Swann Special Care Center	Champaign, IL	Hoosier Care Investme	Nashville, TN	NFP Affiliated Co.
		Vernon Manor Children's Home	Wabash, IN	Loves Park Facility Co	Loves Park, IL	Property Co.
		Richland-Bean Blossom Health Care Center	Ellettsville, IN			
		Exceptional Living Centers of Brazil	Brazil, IN			
		Randolph Nursing Home	Winchester, IN			

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)			
1	V	17 Corporate Group Overhead	\$ 123,121	Hoosier Care, Inc.	100.00%	\$ 103,067	\$	(20,054)	1	
2	V			Note: See Schedule VIII for Allocation of Col. 7 amt and reclassification to functional expense lines on Schedule V.					2	
3	V								3	
4	V								4	
5	V	19 Rel. Party Management Fee	627,600	Medical Rehabilitation Centers, LLC dba Exceptional Living Centers	37.50%	389,884		(237,716)	5	
6	V			Hoosier Care owns a beneficial interest in MRC					6	
7	V			Note: Please see Schedule VIII for Allocation of Col. 7 amt and reclassification to functional expense lines on Sch V.					7	
8	V								8	
9	V								9	
10	V								10	
11	V	PLEASE SEE DISCLOSURE AND DETAIL OF ADJUSTMENTS CONTINUED ON THE NEXT PAGE (6A):								11
12	V								12	
13	V								13	
14	Total		\$ 750,721			\$ 492,951	\$ *	(257,770)	14	

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

Facility Name & ID Number Walter Lawson Childrens Home# 0035469Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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	\$ 546,248	Loves Park Facility Company, LLC	100.00%	\$	\$ (546,248)
16	V			This facility company is under 100% common			
17	V			ownership with WLCH, 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		248,700	248,700
22	V	32 Actual Interest of Rel Pty		-Interest (net of interest income)		176,194	176,194
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		29,643	29,643
25	V	36 Actual Mortgage Ins of Rel Pty		-Mortgage Insurance		34,748	34,748
26	V	19 Actual Accting Fees of Rel Pty		-Accounting Fees		11,893	11,893
27	V						
28	V						
29	V	32 Rel Party Interest/Bldg Financing	30,992	Hoosier Care Investments, LLC	100.00%	30,992	
30	V			This related party, under common control with Hoosier Care,			
31	V			Inc., provided a loan in 2007 to WLCH to finance a building			
32	V			addition. The actual interest expense represents the related			
33	V			party's actual cost of capital, reflecting the interest rate			
34	V			environment at the time of financing, and the fully-subordinated,			
35	V			unsecured nature of the debt, junior to all other obligations of WLCH.			
36	V						
37	V						
38	V						
39	Total		\$ 577,240			\$ 538,867	\$ * (38,373)

* 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: 07/01/2014 Ending: 06/30/2015

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	77,783	17.8
13								TOTAL	\$ 77,783	13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number

Walter Lawson Children's Home

0035469

Report Period Beginning: 7/1/2014

Ending:

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.**

Net allowable amounts paid for Home Office Administration Fees by other Nursing Homes

Walter Lawson Children's Home	77,783	Illinois
Swann Special Care Center	94,719	Illinois
Exceptional Care & Training Center	58,852	Illinois
Vernon Manor Children's Home	56,879	Indiana
Exceptional Living Center of Brazil	70,405	Indiana
Richland-Bean Blossom Health Care	54,005	Indiana
Randolph Nursing Home	52,856	Indiana

Net allowable Related Party Management Fees paid by other Nursing Homes

Walter Lawson Children's Home	389,883	Illinois
Swann Special Care Center	474,774	Illinois
Exceptional Care & Training Center	294,989	Illinois
Vernon Manor Children's Home	285,100	Indiana
Exceptional Living Center of Brazil	352,897	Indiana
Richland-Bean Blossom Health Care	270,693	Indiana
Randolph Nursing Home	264,935	Indiana

Facility Name & ID Number Walter Lawson Childrens Home

0035469 Report Period Beginning: 07/01/2014

Ending: 6/30/2015

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 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	17	Administrative	Direct Cost	42,718,084	7	\$ 465,498	\$ 0	7,138,074	\$ 77,783	1
2	20	Dues, Fees, Subscriptions & Prom	Direct Cost	42,718,084	7	123,820	0	7,138,074	20,690	2
3	21	Clerical & General Office Expens	Direct Cost	42,718,084	7	316	0	7,138,074	53	3
4	32	Interest	Direct Cost	42,718,084	7	27,175	0	7,138,074	4,541	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					\$ 616,809	\$		\$ 103,067	25

Facility Name & ID Number Walter Lawson Childrens Home

0035469 Report Period Beginning: 07/01/2014

Ending: 6/30/2015

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, dba Except
 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	\$ 4,803	\$ 7,138,074	7,138,074	\$ 414	1
2	17	Administrative	Direct Costs	15	2,909,082	2,849,135	7,138,074	250,715	2
3	19	Professional Services	Direct Costs	15	215,236		7,138,074	18,550	3
4	20	Dues, Fees, Subscriptions	Direct Costs	15	27,556		7,138,074	2,375	4
5	21	Clerical & General Office	Direct Costs	15	258,716		7,138,074	22,297	5
6	22	Employee Benefits & Payroll Tax	Direct Costs	15	451,890		7,138,074	38,946	6
7	23	Inservice Training & Education	Direct Costs	15	11,045		7,138,074	952	7
8	24	Travel & Seminar	Direct Costs	15	384,026		7,138,074	33,097	8
9	26	Insurance	Direct Costs	15	42,282		7,138,074	3,644	9
10	30	Depreciation	Direct Costs	15	77,083		7,138,074	6,643	10
11	32	Interest	Direct Costs	15			7,138,074		11
12	34	Rent - Facility & Grounds	Direct Costs	15	133,994		7,138,074	11,548	12
13	35	Rent - Equipment	Direct Costs	15	8,152		7,138,074	703	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				\$ 4,523,865	\$ 2,849,135		\$ 389,884	25

Facility Name & ID Number

Walter Lawson Childrens Home

0035469

Report Period Beginning:

07/01/2014

Ending:

06/30/2015

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	\$ 254,115	04/15/27	0.0800	\$ 30,992						
2	LP Mortgage HUD Loan 2012		X	Purchase of Facility Refi	\$28,956.00	11/01/12	7,290,000	6,871,528	11/01/42	0.0254	176,532						
3																	
4																	
5																	
Working Capital																	
6	GE Healthcare Finance		X	Working Capital		10/27/11	5,000,000		10/27/14	Varies							
7	GE Healthcare Finance		X	Working Capital		06/24/14	5,750,000		10/27/19	Varies							
8																	
9	TOTAL Facility Related				\$54,449.00		\$ 21,040,000	\$ 7,125,643			\$ 207,524						
B. Non-Facility Related*																	
10																	
11																	
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$			\$						
15	TOTALS (line 9+line14)						\$ 21,040,000	\$ 7,125,643			\$ 207,524						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 34,748 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 2014 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 2015 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:	2010	_____	8	FOR BHF USE ONLY	
	2011	_____	9		
	2012	_____	10		
	2013	_____	11		
	2014	_____	12		
Note: This facility became exempt from Property Taxes starting on 1/1/1996.				13	13
Prior year disputes regarding the tax-exempt nature of the property were resolved in favor of WLCH, therefore no further expense or accrual is recognized or required to be disallowed.				14	14
				15	15
				16	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.

2014 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 2014 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 2014.

	(A) <u>Tax Index Number</u>	(B) <u>Property Description</u>	(C) <u>Total Tax</u>	(D) <u>Tax Applicable to Nursing Home</u>
1.	N/A - Tax Exempt		\$	\$
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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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).

WLCH Developmental Day Training Program and Special Education Programs; cost removal adjustments & allocation to remove associated costs shown on SCH V; See Pg 11.2 for further detail

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

Walter Lawson Childrens Home
Schedule X Supplemental Schedule
Item 14 - Allocation of non-long term care costs

(E)

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

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

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

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Accumulated Depreciation
4	93	1989	1971	\$ 2,917,000	\$ 63,425	40	\$ 63,425	\$ 2,023,765
5	6		2008	3,659,316	91,483	40	91,483	663,251
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	2,000.16
22	INSTALL NEW ROOF SHINGLES	11/1/1999		3,727.00	186.35	20-0	186	2,919.52
23	INSTALL	11/29/1999		3,265.00	72.47	15-0	72	3,265.00
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	21,908.82
27	DURO-LAST ROOF SYSTEM.	5/15/2001		40,846.00	1,633.84	25-0	1,634	23,145.98
28	DONATION OF NURSE	10/1/2001		6,594.00	439.60	15-0	440	6,044.43
29	BOOSTER PUMP	12/31/2001		4,837.00	322.47	15-0	322	4,380.17
30	NEW HEAT EXCHANGER,INDUCE	9/20/2002		2,818.15	187.88	15-0	188	2,411.16
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	84,182.48
34	Water heater (75 gallon)	6/30/2006		6,375.89	637.59	10-0	638	5,738.31
35	HVAC unit for B wing	12/19/2006		7,600.00	760.00	10-0	760	6,460.00
36	Rooftop hvac unit	4/24/2008		3,973.00	397.30	10-0	397	2,847.32

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Walter Lawson Childrens Home

0035469

Report Period Beginning:

07/01/2014

Ending:

06/30/2015

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	\$	\$ 2,184.14	37
38	A.O. Smith water heater	8/17/2010	7,018.87	701.89	10-0	702		3,392.47	38
39	Sentronic door closers (2) for old bldg	6/23/2011	3,025.00	302.50	10-0	303		1,210.00	39
40	Remodel C wing bathing room	12/16/2011	10,848.33	723.22	15-0	723		2,531.27	40
41	Rpl roof and ceiling in maintenance shed	1/20/2012	5,450.00	545.00	10-0	545		1,862.08	41
42	Kitchen & dining room remodeling	3/9/2012	19,090.40	1,272.69	15-0	1,273		4,242.30	42
43	West side siding, maint. shop drywall	4/18/2012	4,929.00	492.90	10-0	493		1,560.85	43
44	Exterior lights, interior recep, exit li	7/20/2012	3,304.38	330.44	10-0	330		963.78	44
45	Roof top units (2)	11/19/2012	12,680.00	1,268.00	10-0	1,268		3,275.67	45
46	Pipe Repair/Kitchen Floor Replacement	9/1/2014	3,100.00	258.33	10-0	258		258.33	46
47	Replace Rooftop Heating & Cooling Unit	11/14/2014	6,291.00	419.40	10-0	419		419.40	47
48	Water Conditioners	2/16/2015	10,360.00	345.33	10-0	345		345.33	48
49	Radiator Assembly	3/19/2015	3,855.58	96.39	10-0	96		96.39	49
50	BLACKTOP DRIVEWAY	11/24/1993	10,130.00	-	10-0			10,130.00	50
51	STRIP/SEAL NORTH PARKING	9/25/1995	3,382.00	-	10-0			3,382.00	51
52	PARKING LOT	9/22/1997	9,898.00	-	10-0			9,898.00	52
53	FENCE ON BACK LOT	10/7/1997	5,680.00	-	10-0			5,680.00	53
54	BLACKTOP NEW PARKING,DRIV	7/9/1998	9,752.00	-	10-0			9,752.00	54
55	REPLACE CONCRETE AT PAVIL	9/15/2000	2,700.00	180.00	15-0	180		2,670.00	55
56	Drywell	11/12/2008	12,588.00	629.40	20-0	629		4,196.00	56
57	Concrete gazebo floor & walks	5/11/2012	10,120.50	1,012.05	10-0	1,012		3,204.83	57
58	2 F2900 Controllers and Resin	2/25/2004	5,880.00	-	7-0			5,880.00	58
59	INSTALL SUMP PUMP & MANHO	10/19/1994	3,200.00	-	10-0			3,200.00	59
60	WATER BOOSTER SYS REPLACE	1/30/1995	6,941.00	-	10-0			6,941.00	60
61	INSTALL NEW MIXING VALVE	4/26/1996	2,960.00	-	10-0			2,960.00	61
62									62
63									63
64	Day Training/Education Assets Disallowed (See 5A)			(122,271)		(122,271)			64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 7,267,960	\$ 55,833		\$ 55,833	\$	\$ 3,137,937	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	\$ 93,978	\$ 18,914	\$ 18,914	\$	3-7	\$ 70,134	71
72	Current Year Purchases	35,916	3,929	3,929		5-7	3,929	72
73	Fully Depreciated Assets	587,517	7,104	7,104		3-10	587,517	73
74	Depr Exp - Rel Pty Alloc Sch VIII		6,643	6,643				74
75	TOTALS	\$ 717,412	\$ 36,590	\$ 36,590	\$		\$ 661,581	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	2012 Ford E250 Van w/ Lift	2012	\$ 40,670	\$ 8,134	\$ 8,134	\$	5	\$ 25,080	76
77										77
78										78
79										79
80	TOTALS			\$ 40,670	\$ 8,134	\$ 8,134	\$		\$ 25,080	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)	\$ 8,710,470	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 100,557	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 100,557	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)	\$ 3,824,597	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	Transportation Equip Not Allowed	\$ 54,648	\$	\$ 54,648	86
87	Assets below IL Capital Threshold	409,250	18,220	348,496	87
88	Other Assets Disallowed	285,913	14,296	252,557	88
89					89
90					90
91	TOTALS	\$ 749,811	\$ 32,516	\$ 655,701	91

G. Construction-in-Progress

	Description	Cost	
92	Matrix Implementation	\$ 733	92
93			93
94			94
95		\$ 733	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: 07/01/2014

Ending: 06/30/2015

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	11,548	10	10	6
7	TOTAL				\$ 11,548			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. 6/30/2016 \$ Corp Alloc Amt

13. 6/30/2017 \$ Corp Alloc Amt

14. 6/30/2018 \$ 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: \$ 7,619 Description: Postage Meter: \$1,023; Short Term Medical Equip: \$5,893; Corp Alloc: \$703

(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.

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? <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><u>Aides are either non-certified, hired with certification, or become certified as D.S.P.s rather than CNAs</u></p>	<p>2. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 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		542	37,905		542	37,905	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.1	2060 hrs	76,714				2,060	76,714	4
5	Physician Care		visits							5
6	Dental Care	39.3	visits			600			600	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39.3	# of prescripts		66	4,269		66	4,269	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>Note: Line 6 Dental Care is flat fee \$50/month dental evals</u>									13
14	TOTAL			\$ 76,714	607	\$ 42,774	\$	2,667	\$ 119,488	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: 07/01/2014Ending: 06/30/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2015 (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	\$ 500	\$ 900	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>44,700</u>)	1,410,050	1,410,050	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	20,362	33,819	6
7	Other Prepaid Expenses	4,941	4,941	7
8	Accounts Receivable (owners or related parties)	4,792,849	4,792,849	8
9	Other(specify): <u>Rounding</u>	2		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,228,704	\$ 6,242,559	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		7,690,216	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost		1,085,637	16
17	Accumulated Depreciation (book methods)		(4,480,298)	17
18	Deferred Charges		183,187	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		403,598	21
22	Other Long-Term Assets (spec CIP)		733	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	\$ 5,828,632	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,489,835	\$ 12,071,191	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 157,328	\$ 157,328	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	254,115	429,080	29
30	Accrued Salaries Payable	364,095	364,095	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,000	6,000	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	1,242	15,787	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Intercompany payables</u>		4,858	36
37	<u>Rounding</u>		(4)	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 782,780	\$ 977,144	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,696,563	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 6,696,563	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 782,780	\$ 7,673,707	46
47	TOTAL EQUITY(page 18, line 24)	\$ 5,707,055	\$ 4,397,484	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,489,835	\$ 12,071,191	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,552,783	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,552,783	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,154,272	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,154,272	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)	\$ 5,707,055	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	\$ 6,935,488	1	
2	Discounts and Allowances for all Levels	(13)	2	
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,935,475	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	1,252,972	9	
10	Other Government Grants	59,631	10	
11	CNA Training Reimbursements	9,520	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	179	21	
22	Laundry		22	
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,322,302	23	
D. Non-Operating Revenue				
24	Contributions	95,825	24	
25	Interest and Other Investment Income***	20	25	
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 95,845	26	
E. Other Revenue (specify):****				
27	Settlement Income (Insurance, Legal, Etc.)	376	27	
28	Day Training	863,879	28	
28a			28a	
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 864,255	29	
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,217,877	30	

		2		
II. Expenses		Amount		
A. Operating Expenses				
31	General Services	861,945	31	
32	Health Care	3,276,780	32	
33	General Administration	1,841,190	33	
B. Capital Expense				
34	Ownership	584,156	34	
C. Ancillary Expense				
35	Special Cost Centers	1,095,862	35	
36	Provider Participation Fee	403,672	36	
D. Other Expenses (specify):				
37			37	
38			38	
39			39	
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,063,605	40	
41	Income before Income Taxes (line 30 minus line 40)**	1,154,272	41	
42	Income Taxes		42	
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,154,272	43	

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 6,935,475	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)	\$ 6,935,475	49

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

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

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

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

Facility Name & ID Number Walter Lawson Childrens Home

0035469

Report Period Beginning: 07/01/2014

Ending: 06/30/2015

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,814	2,054	\$ 145,214	\$ 70.70	1
2	Assistant Director of Nursing					2
3	Registered Nurses	20,162	22,255	681,102	30.60	3
4	Licensed Practical Nurses	18,184	20,432	658,538	32.23	4
5	CNAs & Orderlies	103,383	112,184	1,301,977	11.61	5
6	CNA Trainees					6
7	Licensed Therapist	1,861	2,060	76,714	37.24	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,911	2,150	34,555	16.07	9
10	Activity Assistants	4,801	5,078	44,658	8.79	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,001	2,127	40,728	19.15	13
14	Head Cook	6,573	7,250	90,098	12.43	14
15	Cook Helpers/Assistants	1,079	1,156	10,732	9.28	15
16	Dishwashers					16
17	Maintenance Workers	3,807	4,060	53,236	13.11	17
18	Housekeepers	13,693	15,021	191,198	12.73	18
19	Laundry	7,929	8,449	80,845	9.57	19
20	Administrator	1,955	2,183	120,668	55.28	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,347	4,769	97,977	20.54	24
25	Vocational Instruction	55,367	60,546	1,011,770	16.71	25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	248,867	271,774	\$ 4,640,010 *	\$ 17.07	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	284	\$ 11,363	1.3	35
36	Medical Director	N/A	13,750	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant	N/A	16,891	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	Note: Medical Dir paid flat fee, not hourly				48
49	TOTAL (lines 35 - 48)	284	\$ 42,004		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

Facility Name & ID Number

Walter Lawson Children's Home # 0035469 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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

DATE	DESCRIPTION	Amount
1 Legal Fees detail for SCH XIX-C		
8/19/2014	SmithAmundsen	\$ 375.00
11/19/2014	SmithAmundsen	\$ 475.00
12/9/2014	Baker, Donelson, Bearman, Caldwell & Berkowi	\$ 252.00
12/9/2014	SmithAmundsen	\$ 50.00
12/15/2014	Baker, Donelson, Bearman, Caldwell & Berkowi	\$ 1,025.00
2/3/2015	Duane Morris LLP	\$ 21.84
4/21/2015	Duane Morris LLP	\$ 23.00
5/8/2015	Baker, Donelson, Bearman, Caldwell & Berkowi	\$ 189.00
6/17/2015	Duane Morris LLP	\$ 22.67
6/17/2015	SmithAmundsen	\$ 200.00
6/17/2015	Stites&Harbison PLLC	\$ 139.34
12/15/2014	DeWitt Ross & Stevens	\$ 31.88
5/29/2015	Stites&Harbison PLLC	\$ 106.00
5/29/2015	Stites&Harbison PLLC	\$ 253.34
7/31/2014	In-House Counsel Legal Fees	\$ 1,036.25
8/31/2014	In-House Counsel Legal Fees	\$ 1,109.52
9/30/2014	In-House Counsel Legal Fees	\$ 1,028.24
10/31/2014	In-House Counsel Legal Fees	\$ 1,099.87
11/30/2014	In-House Counsel Legal Fees	\$ 1,096.75
12/31/2014	In-House Counsel Legal Fees	\$ 838.12
1/31/2015	In-House Counsel Legal Fees	\$ 1,151.34
2/28/2015	In-House Counsel Legal Fees	\$ 1,037.67
3/31/2015	In-House Counsel Legal Fees	\$ 1,138.51
4/30/2015	In-House Counsel Legal Fees	\$ 784.28
5/31/2015	In-House Counsel Legal Fees	\$ 794.15
6/30/2015	In-House Counsel Legal Fees	\$ 827.29
		<u>\$ 15,106</u>

See Schedule VI for adjustment for unallowable portion.

Facility Name & ID Number

Walter Lawson Children's Home

STATE OF ILLINOIS

0035469

Report Period Beginning:

7/1/2014

Ending:

Walter Lawson Children's Home
 Schedule XIX Supplemental Schedule
 Travel & Seminar In-State detail:

DESCRIPTION	Amount	SCH V LINE.COL
<u>1 In-State Travel Detail</u>		
Melissa Thornbloom, Exec Dir, care-related in-state travel	858	24.3
Wynell Prince Eakle, Regional A/R	A 564	24.3
Jan Primuth, DoN, care-related in-state travel	326	24.3
Katie Johnson, Dietary, care-related in-state travel	84	24.3
Donna Ploum, Bus Office Mgr, care-related in-state travel	81	24.3
Paula Braconier, Bus Office, care-related in-state travel	95	24.3
Corporate/Group travel allocation of operations personnel	1,765	24.3
In-state business meals	A 67	24.3
Donation for in-state travel costs	A (356)	24.3
	<u>3,483</u>	
<u>1 Out of State Travel Detail</u>		
Melissa Thornbloom, Exec Dir, care-related in-state travel	<u>996</u>	24.3
	996	
Line 24 Column 4 Total:	<u><u>4,479</u></u>	(0)
Line 24 Column 5 Reclassification - Corporate/Home Office A	33,097	0
<i>Unallowable Amounts above removed through SCH 5 Adjustments:</i>		
A Non-care related amounts noted above:	(274)	
Allocation for non-care-related Education and Day Training (See Pg 11.2 & 5A)	(4,497)	
Line 24 Column 8 Total:	<u><u>32,805</u></u>	(0)

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: 07/01/2014Ending: 06/30/2015**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, \$4,069 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. \$ 85,347 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 403,672
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? Yes; See Pg 11.2 For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ _____ Has any meal income been offset against related costs? Yes Indicate the amount. \$ 59,631
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Crowe Horwath
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.