

Facility Name & ID Number Walter Lawson Childrens Home

0035469 Report Period Beginning: 07/01/2016 Ending: 06/30/2017

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 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF					8
9	SNF/PED	35,347			35,347	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	35,347			35,347	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.82%

D. How many bed reserve days during this year were paid by the Department?
168 (Do not include bed reserve 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 06/30/2017 Fiscal Year: FYE 06/30/2017

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

Facility Name & ID Number Walter Lawson Childrens Home # 0035469 Report Period Beginning: 07/01/2016 Ending: 06/30/2017

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	142,389	6,155	12,758	161,302		161,302	(63,498)	97,804		1
2	Food Purchase		271,488		271,488		271,488	(106,875)	164,613		2
3	Housekeeping	197,950	19,893		217,843		217,843	(104,313)	113,530		3
4	Laundry	81,315	7,001	631	88,947		88,947	(976)	87,971		4
5	Heat and Other Utilities			88,570	88,570		88,570	(43,438)	45,132		5
6	Maintenance	60,889	13,196	49,796	123,881		123,881	(59,290)	64,591		6
7	Other (specify):*										7
8	TOTAL General Services	482,543	317,733	151,755	952,031		952,031	(378,390)	573,641		8
	B. Health Care and Programs										
9	Medical Director			13,000	13,000		13,000		13,000		9
10	Nursing and Medical Records	2,860,989	278,997	594	3,140,580	(42,555)	3,098,025	(90,389)	3,007,636		10
10a	Therapy	82,422	11,332	38,623	132,377		132,377	(57,143)	75,234		10a
11	Activities	74,722	424		75,146		75,146		75,146		11
12	Social Services										12
13	CNA Training					42,555	42,555		42,555		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,018,133	290,753	52,217	3,361,103		3,361,103	(147,532)	3,213,571		16
	C. General Administration										
17	Administrative	129,664			129,664		129,664	117,929	247,593		17
18	Directors Fees			92,940	92,940		92,940	(25,907)	67,033		18
19	Professional Services			553,937	553,937		553,937	(491,651)	62,286		19
20	Dues, Fees, Subscriptions & Promotions			94,225	94,225		94,225	(60,711)	33,514		20
21	Clerical & General Office Expenses	109,084	7,207	52,930	169,221		169,221	(169,221)			21
22	Employee Benefits & Payroll Taxes			798,243	798,243		798,243	(149,597)	648,646		22
23	Inservice Training & Education			16,949	16,949		16,949	(3,881)	13,068		23
24	Travel and Seminar			3,082	3,082		3,082	21,492	24,574		24
25	Other Admin. Staff Transportation			625	625		625		625		25
26	Insurance-Prop.Liab.Malpractice			48,361	48,361		48,361	(36)	48,325		26
27	Other (specify):* Indigent Care			28,109	28,109		28,109	(28,109)			27
28	TOTAL General Administration	238,748	7,207	1,689,401	1,935,356		1,935,356	(789,693)	1,145,663		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,739,424	615,693	1,893,373	6,248,490		6,248,490	(1,315,615)	4,932,875		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:

07/01/2016

Ending:

06/30/2017

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation							97,149	97,149		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			11,072	11,072		11,072	83,202	94,274		32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds			548,792	548,792		548,792	(541,284)	7,508		34
35	Rent-Equipment & Vehicles			3,902	3,902		3,902	(1,008)	2,894		35
36	Other (specify):* MIP							16,772	16,772		36
37	TOTAL Ownership			563,766	563,766		563,766	(345,169)	218,597		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		6,416	5,096	11,512		11,512		11,512		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			417,452	417,452		417,452		417,452		42
43	Other (specify):* Direct GL EDU &	1,105,713		82,102	1,187,815		1,187,815	(1,187,815)			43
44	TOTAL Special Cost Centers	1,105,713	6,416	504,650	1,616,779		1,616,779	(1,187,815)	428,964		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,845,137	622,109	2,961,789	8,429,035		8,429,035	(2,848,599)	5,580,436		45

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

Walter Lawson Children's Home
Schedule V - Line 23 Detailed Schedule

Purpose of Seminar	Name of Attendeed	Title of Attendee	Exp Amount
Relias Learning Core Curriculum Education Software (Billed Quarterly)	All Employees		13,771.29
B. Williams Enterprise LLC Employee Service & Leadership Training	All Employees		154.50
American Red Cross Adult and Pediatric First Aid/CPR Sessions	Various Employees		2,148.00
A ACT Workkeys Assessments	Various Employees	Business Office	60.25
A Illinois Alliance of Administrators of Special Education 18th Annual Fall Conference	Katie Johnson	Education - Teacher	175.00
Proficio Consulting Group Nonpublic Conference	Melissa Thornbloom	Executive Director	300.00
A Allocated Regional Support Costs			340.24
Line 23 Column 4 Total:			16,949
Line 23 Column 7 Adjustment - Corporate/Home Office Allocated Costs:			1,672
Line 23 Column 6 Total:			18,621
<i>Unallowable Amounts above removed through SCH 5 Adjustments:</i>			
A Non-care related amounts noted above:			(575)
Allocation for non-care-related Education and Day Training (See Pg 11.2 & 5A)			(4,978)
Line 23 Column 8 Total:			13,068
			0

Exceptional Care & Training Center
Schedule V Supplemental Schedule
Reclassifications

DESCRIPTION INCREASE / (DECREASE) SCH V LINE.COL

1 Reclassification of C.N.A. Training Expenses for Trainers/Trainees

C.N.A. Training	42,555	13.5
Nursing & Medical Records	(42,555)	10.5

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	(1,187,815)	43		3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(3,661)	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				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	(706)	20		18
19	Entertainment				19
20	Contributions	(25,716)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,440)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(28,109)	27		24
25	Fund Raising, Advertising and Promotional	(13,846)	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	(1,366,759)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,628,052)		\$	30

BHF USE ONLY							
48		49		50		51	
							52

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

		1	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)	(220,547)	19, 34	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (220,547)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (2,848,599)		37

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

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

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

Walter Lawson Childrens Home

ID# 0035469

Report Period Beginning: 07/01/2016

Ending: 06/30/2017

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	Sch. V Line
1	Income Offset - Contributions Received	\$ (126,398)	21	1
2	Income Offset - Contributions Received	(15,620)	17	2
3	Unallowable Depr Exp (below threshold, non-cap)	(33,832)	30	3
4	Unallowable Lobbying Portion of ILHCA Dues	(1,785)	20	4
5	Unallowable Portion of Inservice Training/Edu	(575)	23	5
6	Unallowable Portion of Travel/Seminar	(1,178)	24	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14	Unallowable Day Trng & EDU Alloc - Dietary	(63,498)	1	14
15	Unallowable Day Trng & EDU Alloc - Food	(106,875)	2	15
16	Unallowable Day Trng & EDU Alloc - Hskpg	(104,313)	3	16
17	Unallowable Day Trng & EDU Alloc - Laundry	(976)	4	17
18	Unallowable Day Trng & EDU Alloc - Heat/Util	(42,411)	5	18
19	Unallowable Day Trng & EDU Alloc - Maint	(59,319)	6	19
20	Unallowable Day Trng & EDU Alloc - Nursing	(90,389)	10	20
21	Unallowable Day Trng & EDU Alloc - Therapy	(57,143)	10a	21
22	Unallowable Day Trng & EDU Alloc - Admin	(38,083)	17	22
23	Unallowable Day Trng EDU Dir Fees	(25,907)	18	23
24	Unallowable Day Trng & EDU Alloc - Prof Svcs	(81,127)	19	24
25	Unallowable Day Trng & EDU Alloc - Dues/Fees	(21,434)	20	25
26	Unallowable Day Trng & EDU Alloc - Clerical	(48,979)	21	26
27	Unallowable Day Trng & EDU Alloc - EE Ben/PR Tax	(175,220)	22	27
28	Unallowable Day Trng & EDU Alloc - Insrv/Training	(4,978)	23	28
29	Unallowable Day Trng & EDU Alloc - Travel/Seminar	(394)	24	29
30	Unallowable Day Trng & EDU Alloc - Admin Trans	0	25	30
31	Unallowable Day Trng & EDU Alloc - Insur	(23,157)	26	31
32	Unallowable Day Trng & EDU Alloc - Interest	(5,302)	32	32
33	Unallowable Day Trng & EDU Alloc - Bldg Rent	(1,524)	35	33
34				34
35	Unallowable Day Trng & EDU Alloc - Depreciation	(117,556)	30	35
36	Unallowable Day Trng & EDU Alloc - Interest	(82,252)	32	36
37	Unallowable Day Trng & EDU Alloc - Amort of Debt	(3,207)	32	37
38	Unallowable Day Trng & EDU Alloc - Insurance	(12,073)	26	38
39	Unallowable Day Trng & EDU Alloc - Mort. Ins.	(16,225)	36	39
40	Unallowable Day Trng & EDU Alloc - Acct. Fees	(5,028)	19	40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,366,759)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Walter Lawson Childrens Home# 0035469

Report Period Beginning:

07/01/2016

Ending:

06/30/2017

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	(63,498)	0	0	0	0	0	0	0	0	0	0	(63,498)	1
2	Food Purchase	(106,875)	0	0	0	0	0	0	0	0	0	0	(106,875)	2
3	Housekeeping	(104,313)	0	0	0	0	0	0	0	0	0	0	(104,313)	3
4	Laundry	(976)	0	0	0	0	0	0	0	0	0	0	(976)	4
5	Heat and Other Utilities	(46,072)	0	2,634	0	0	0	0	0	0	0	0	(43,438)	5
6	Maintenance	(59,319)	0	29	0	0	0	0	0	0	0	0	(59,290)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(381,053)	0	2,663	0	0	0	0	0	0	0	0	(378,390)	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	(90,389)	0	0	0	0	0	0	0	0	0	0	(90,389)	10
10a	Therapy	(57,143)	0	0	0	0	0	0	0	0	0	0	(57,143)	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	(147,532)	0	0	0	0	0	0	0	0	0	0	(147,532)	16
	C. General Administration													
17	Administrative	(53,703)	0	171,632	0	0	0	0	0	0	0	0	117,929	17
18	Directors Fees	(25,907)	0	0	0	0	0	0	0	0	0	0	(25,907)	18
19	Professional Services	(87,595)	0	(415,056)	11,000	0	0	0	0	0	0	0	(491,651)	19
20	Fees, Subscriptions & Promotions	(63,487)	0	2,776	0	0	0	0	0	0	0	0	(60,711)	20
21	Clerical & General Office Expenses	(175,377)	0	6,156	0	0	0	0	0	0	0	0	(169,221)	21
22	Employee Benefits & Payroll Taxes	(175,220)	0	25,623	0	0	0	0	0	0	0	0	(149,597)	22
23	Inservice Training & Education	(5,553)	0	1,672	0	0	0	0	0	0	0	0	(3,881)	23
24	Travel and Seminar	(1,572)	0	23,064	0	0	0	0	0	0	0	0	21,492	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(35,230)	0	2,283	32,911	0	0	0	0	0	0	0	(36)	26
27	Other (specify):*	(28,109)	0	0	0	0	0	0	0	0	0	0	(28,109)	27
28	TOTAL General Administration	(651,754)	0	(181,850)	43,911	0	(789,693)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,180,339)	0	(179,187)	43,911	0	(1,315,615)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Walter Lawson Childrens Home# 0035469

Report Period Beginning:

07/01/2016 Ending:06/30/2017

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(151,388)	0	2,101	246,436	0	0	0	0	0	0	0	97,149	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(90,761)	0	0	173,963	0	0	0	0	0	0	0	83,202	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	7,508	(548,792)	0	0	0	0	0	0	0	(541,284)	34
35	Rent-Equipment & Vehicles	(1,524)	0	516	0	0	0	0	0	0	0	0	(1,008)	35
36	Other (specify):*	(16,225)	0	0	32,997	0	0	0	0	0	0	0	16,772	36
37	TOTAL Ownership	(259,898)	0	10,125	(95,396)	0	(345,169)	37						
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(1,187,815)	0	0	0	0	0	0	0	0	0	0	(1,187,815)	43
44	TOTAL Special Cost Centers	(1,187,815)	0	0	0	0	0	0	0	0	0	0	(1,187,815)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(2,628,052)	0	(169,062)	(51,485)	0	(2,848,599)	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.
		Exceptional Living of Brazil	Brazil, IN	Loves Park Facility Co	Loves Park, IL	Property Co.
		Richland-Bean Blossom Health Care	Ellettsville, IN			
		Vernon Manor Children's Home	Wabash, IN			
		Randolph Nursing Home	Winchester, IN			
		Claremont Center	Point Pleasant, NJ			

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
1	V	18 Group Mgmt/Dir Fees	\$ 92,940	Hoosier Care, Inc.	100.00%	\$ 92,940	\$	1	
2	V			Note: See Schedule VII Section C for description				2	
3	V							3	
4	V							4	
5	V							5	
6	V	PLEASE SEE CONTINUED DISCLOSURE AND DETAIL OF ADJUSTMENTS ON THE NEXT PAGE (6A):							6
7	V							7	
8	V							8	
9	V							9	
10	V							10	
11	V							11	
12	V							12	
13	V							13	
14	Total		\$ 92,940			\$ 92,940	\$ *	14	

* 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:

07/01/2016

Ending:

06/30/2017

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Churchman Village	Newark, DE				1
2			Harbor Health Care	Lewes, DE				2
3			Parkview Nursing	Wilmington, DE				3
4			Clearwater Care Center	Eau Claire, WI				4
5			Bethel Center	Arpin, WI				5
6			Colonial Center	Colby, WI				6
7			Karmenta Center	Madison, WI				7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

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	19 Rel. Party Management Fee	\$ 435,989	Medical Rehabilitation Centers, LLC	37.50%	\$	\$ (435,989)	
16	V			dba Exceptional Living Centers				
17	V			Hoosier Care owns a beneficial interest in MRC				
18	V			Note: Please see Schedule VIII for detail of Col. 7 amts				
19	V	5 Utilities				2,634	2,634	
20	V	6 Maintenance				29	29	
21	V	17 Administrative				171,632	171,632	
22	V	19 Professional Services				20,933	20,933	
23	V	20 Dues, Fees, Subscriptions				2,776	2,776	
24	V	21 Clerical & General Office				6,156	6,156	
25	V	22 Employee Benefits & Payroll Taxes				25,623	25,623	
26	V	23 Inservice Training & Education				1,672	1,672	
27	V	24 Travel & Seminar				23,064	23,064	
28	V	26 Insurance				2,283	2,283	
29	V	30 Depreciation				2,101	2,101	
30	V	34 Rent - Facility & Grounds				7,508	7,508	
31	V	35 Rent - Equipment				516	516	
32	V							
33	V							
34	V							
35	V							
36	V							
37	V	PLEASE SEE CONTINUED DISCLOSURE AND DETAIL OF ADJUSTMENTS ON THE NEXT PAGE (6A):						
38	V							
39	Total		\$ 435,989			\$ 266,927	\$ * (169,062)	

* 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	\$ 548,792	Loves Park Facility Company, LLC		\$	\$ (548,792)
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		246,436	246,436
22	V	32 Actual Interest (net) of Rel Pty		-Interest (net of interest income)		167,266	167,266
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		32,911	32,911
25	V	36 Actual Mortgage Ins of Rel Pty		-Mortgage Insurance		32,997	32,997
26	V	19 Actual Accting Fees of Rel Pty		-Accounting Fees		11,000	11,000
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 548,792			\$ 497,307	\$ * (51,485)

* 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:

07/01/2016

Ending:

06/30/2017

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 Foes	Board Member	Governance	0%					\$		1
2	John Gillmor	Board Member	Governance	0%							2
3	Jim Ridenour	Board Member	Governance	0%							3
4	Jo Anne Corbitt	Board Member	Governance	0%							4
5	Douglass Smith	Board Member	Governance	0%							5
6	Stephen Wood	Board Member	Governance	0%							6
7	Andrea Barach	Board Member	Governance	0%							7
8	NOTE: Fees are paid by WLCH to Hoosier Care Investments, LLC ("HCI"; an affiliated not-for-profit) which go toward fees for members of the Boards of Directors										8
9	of HCI affiliated facilities, Walter Lawson Children's Home being one of many. Therefore no Board Fees or compensation paid directly by WLCH to the										9
10	Directors, but rather the fees paid by WLCH to HCI are combined with similar fees paid by other facilities, for HCI to provide governance and managerial oversight,										10
11	including payment by HCI to Board members of each legal entity. Fees paid by other IL facilities are shown on Page 7.1.										11
12	The entire amount of fees included on this report, grouped on Line 18, is disclosed here at actual cost to the facility:										12
								ADMIN FEES	92,940	18.8	
13								TOTAL	\$ 92,940		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

Swann Special Care Center

0035485

Report Period Beginning:

7/1/2016

Ending:

6/30/2017

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 Directors/Administration Fees by other Nursing Homes

Walter Lawson Children's Home	92,940
Swann Special Care Center	115,476
Exceptional Care & Training Center	78,864

Facility Name & ID Number Walter Lawson Childrens Home

0035469

Report Period Beginning:

07/01/2016

Ending: 6/30/2017

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

Name of Related Organization 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

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	5	Utilities	Direct Cost	306,053	\$ 266,927	\$	3,020	\$ 2,634	1
2	6	Maintenance	Direct Cost	306,053	266,927		33	29	2
3	17	Administrative	Direct Cost	306,053	266,927		196,790	171,632	3
4	19	Professional Services	Direct Cost	306,053	266,927		24,002	20,934	4
5	20	Dues, Fees, Subscriptions	Direct Cost	306,053	266,927		3,183	2,776	5
6	21	Clerical & General Office	Direct Cost	306,053	266,927		7,058	6,156	6
7	22	Employee Benefits & Payroll Tax	Direct Cost	306,053	266,927		29,379	25,623	7
8	23	Inservice Training & Education	Direct Cost	306,053	266,927		1,917	1,672	8
9	24	Travel & Seminar	Direct Cost	306,053	266,927		26,445	23,064	9
10	26	Insurance	Direct Cost	306,053	266,927		2,618	2,283	10
11	30	Depreciation	Direct Cost	306,053	266,927		2,409	2,101	11
12	32	Interest	Direct Cost	306,053	266,927		0	0	12
13	34	Rent - Facility & Grounds	Direct Cost	306,053	266,927		8,609	7,508	13
14	35	Rent - Equipment	Direct Cost	306,053	266,927		591	515	14
15									15
16									16
17		Please see attached allocation workpaper							17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 3,736,976	\$		\$ 266,927	25

VIII. ALLOCATION OF INDIRECT COSTS (continued)

A. Are there any costs included in this report which were derived from allocation of central office or general organization cost? (See instructions.) YES NO Name of Related Organization: **Medical Rehabilitation Center, LLC, Also, Occupational Living Center**
 Street Address: **1000 North State Street, 200**
 City / State / Zip Code: **Chicago, IL 60610**
 Phone Number: **800-255-0000**
 Fax Number: **800-255-0000**

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

Water Lawan Children's Home	202,027
Seam Special Care Center	107,025
Exceptional Care & Training Center	107,025
Exceptional Living of Brook	107,025
Richardson-Brown HealthCare	107,025
Water Lawan Children's Home	214,054
Rehabilitation Home	214,054
Channahon Center	214,054
Channahon Village	214,054
Water Lawan	214,054
Peoria Home	214,054
Channahon Center	214,054
Water Lawan	214,054
Channahon Center	214,054
Water Lawan	214,054

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

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

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

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

Facility	Operating Expense FY 2023/24	Facility GL Mgmt FY 2023/24	Percent Alloc	Actual Cost
ELC Care Center	5,156,728	7,428	7.03%	360,264 (not related)
Exceptional Rehabilitation	8,124,728	7,428	7.03%	450,264 (not related)
Medical Care Center	4,744,496	154,044	3.26%	187,044
Medical Care Center	4,446,168	154,044	3.40%	188,044
Seamless Care Center	5,156,728	154,044	3.19%	178,044
Management Care Center	7,428,728	154,044	2.08%	100,044
Subtotal All Wisconsin Facilities	31,122,554	11,938,204	38.36%	663,400
Madison Branch	4,446,168	119,044	2.68%	136,704 (not related)
Madison City	7,428,728	119,044	1.60%	76,704 (not related)
Madison All Indiana Facilities	7,428,728	119,044	1.60%	100,044 (not related)
Total American Sign	19,283,624	23,888,204	124.35%	3,237,440
ELC Brook	5,156,728	447,244	8.67%	242,044
Rehabilitation Home	5,156,728	447,244	8.67%	210,044
Richardson-Brown	5,156,728	447,244	8.67%	217,044
Water Lawan	5,156,728	447,244	8.67%	227,044
Subtotal All Indiana Facilities	20,426,912	1,788,776	8.75%	696,136
Exceptional Care Training Center	5,156,728	187,044	3.63%	221,044
Seam Special Care Center	4,744,496	187,044	3.94%	241,044
Water Lawan	7,428,728	187,044	2.52%	160,044
Seamless Care Group Facilities	7,428,728	187,044	2.52%	188,704
Water	11,242,624	847,244	7.54%	574,444
Peoria	12,446,224	778,244	6.26%	508,044
Channahon	7,428,728	484,244	6.52%	410,044
Water Lawan	5,156,728	187,044	3.63%	239,044
Seamless Care Group	4,744,496	413,244	8.71%	370,136
Total Missouri Care	48,480,448	68,428,204	141.33%	2,738,400
Total ELC Facilities under Mgmt	128,474,464	188,428,204	146.65%	10,000,000

Note 1: Operating Expense determined for calendar year period regardless of FY of individual building. Operating Expense report Quarterly Expense per Facility Statement. Qtrly only. Management Fee per Facility GL.

ILRHSO ALLOCATION & CHALLENGES FOR IMPROVED PAY AND REDUCTION OF RISKY PAY RISK TO PROPORTIONAL CONTRIBUTION RISK

Costs per Facility/Program	Split among programs per Subgrouping Alloc			% of Total by Program		
	DNF	EDU	DT	DNF	EDU	DT
Exceptional Care Training Center	208,883	191	188	85%	2%	12%
Seam Special Care Center	400,188	1,223	18,888	85%	2%	12%
Water Lawan	300,000	24,000	38,000	87%	2%	8%
Adjusted to CHSDH Care Mgmt						
Remaining Amount in Adjusted DNF amt:	208,883					
Seam Special Care Center	400,188					
Water Lawan	420,988					
Ratio of Allowable Costs to Unallocated GL Management Fee per Facility Allocation above:						
Exceptional Care Training Center	97%					
Seam Special Care Center	84%					
Water Lawan	61%					
Calculate remaining allowable related party management fee (Total):						
Exceptional Care Training Center	187,552					
Seam Special Care Center	300,883					
Water Lawan	260,900					
Check: Net adjustment by reducing remaining GL amt to allowable net party cost/functional expenses below:						
Exceptional Care Training Center	111,223					
Seam Special Care Center	171,134					
Water Lawan	100,657					
Recovery remaining allocation remaining related party management fee to functional expense categories for final CR presentation:						

Exceptional Care Training Center

Percentage of grouped CR Line to total exp	Amount to be allocated to CR Line
Utilities	0.9%
Maintenance	0.1%
Administrative	64.3%
Professional Services	1.8%
Desk, Fax, Subscriptions	1.9%
Client & General Office	2.3%
Employee Benefits & Payroll Taxes	0.0%
Insurance Training & Education	0.0%
Travel & Services	0.4%
Other Administrative Transportation	0.0%
Insurance	0.8%
Depreciation	0.7%
Interest	0.0%
Real - Facility & Grounds	2.8%
Real - Equipment	0.1%
Total	100.0%

Seam Special Care Center

Percentage of grouped CR Line to total exp	Amount to be allocated to CR Line
Utilities	0.9%
Maintenance	0.1%
Administrative	64.3%
Professional Services	1.8%
Desk, Fax, Subscriptions	1.9%
Client & General Office	2.3%
Employee Benefits & Payroll Taxes	0.0%
Insurance Training & Education	0.0%
Travel & Services	0.4%
Other Administrative Transportation	0.0%
Insurance	0.8%
Depreciation	0.7%
Interest	0.0%
Real - Facility & Grounds	2.8%
Real - Equipment	0.1%
Total	100.0%

Water Lawan Children's Home

Percentage of grouped CR Line to total exp	Amount to be allocated to CR Line
Utilities	0.9%
Maintenance	0.1%
Administrative	64.3%
Professional Services	1.8%
Desk, Fax, Subscriptions	1.9%
Client & General Office	2.3%
Employee Benefits & Payroll Taxes	0.0%
Insurance Training & Education	0.0%
Travel & Services	0.4%
Other Administrative Transportation	0.0%
Insurance	0.8%
Depreciation	0.7%
Interest	0.0%
Real - Facility & Grounds	2.8%
Real - Equipment	0.1%
Total	100.0%

Facility Name & ID Number

Walter Lawson Childrens Home

0035469

Report Period Beginning:

07/01/2016

Ending:

06/30/2017

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 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Interest Expense	10
		YES	NO				Original	Balance				
A. Directly Facility Related												
Long-Term												
1	LP Mortgage HUD Loan 2012		X	Purchase of Facility Refi	\$28,956.00	11/01/12	\$ 7,290,000	\$ 6,517,102	11/01/42	0.0254	\$ 167,633	1
2												2
3												3
4												4
5												5
Working Capital												
6	GE Healthcare Finance		X	Working Capital	\$0.00	06/24/14	5,750,000	\$0.00	10/27/19	Varies	\$0.00	6
7												7
8												8
9	TOTAL Facility Related				\$28,956.00		\$ 13,040,000	\$ 6,517,102			\$ 167,633	9
B. Non-Facility Related*												
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 13,040,000	\$ 6,517,102			\$ 167,633	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 32,997 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 2016 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 2017 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:	2012	8
	2013	9
	2014	10
	2015	11
	2016	12

Note: This facility became exempt from Property Taxes starting on 1/1/1996.

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2016	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

2016 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 2016 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 2016.

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

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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:

A. Land.

Table with 6 columns: Use, Square Feet, Year Acquired, Cost, and two unlabeled columns. Rows include SNF/PED, 2, and TOTALS.

Walter Lawson Children's 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.

Facility Name & ID Number Walter Lawson Childrens Home

0035469

Report Period Beginning:

07/01/2016

Ending:

06/30/2017

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	93		1989	1971	\$ 2,917,000	\$ 63,425	10-40	\$ 63,425	\$	\$ 2,150,615	4
5	6			2008	3,659,316	91,483	40	91,483		846,217	5
6											6
7											7
8											8
	Improvement Type**										
9		CARRIER HEAT/AIR CONDITIO		1/11/1990	17,400		5			17,400	9
10		INSTALL NEW WINDOWS		12/20/1995	2,588		10			2,588	10
11		TILE KITCHEN FLOOR		1/31/1996	5,187		10			5,187	11
12		INSTALL WATER HEATER		3/19/1996	4,981		10			4,981	12
13		INSTALL WATER HEATER		2/11/1997	6,014		10			6,014	13
14		SHOWER TROLLEY		3/11/1997	10,924		10			10,924	14
15		RE-ROOF NORTH WING,GRAVEL		6/18/1997	27,596		10			27,596	15
16		INSTALL A/C ROOF-TOP UNIT		7/16/1997	2,975		10			2,975	16
17		INSTALL EMERGENCY GENERAT		1/12/1998	85,329		10			85,329	17
18		NEW ROOF TOP HVAC UNIT		1/19/1999	4,340		10			4,340	18
19		INSTALL NEW ROOF SHINGLES		11/1/1999	3,727	186	20	186		3,292	19
20		INSTALL		11/29/1999	3,265		15			3,265	20
21		PARTIAL PMT-TELEPHONE SYS		3/27/2000	3,264		10			3,264	21
22		PARTIAL PMT-TELEPHONE SYS		3/27/2000	6,528		10			6,528	22
23		FIRE SPRINKLER SYSTEM.		1/15/2001	37,774	1,511	25	1,511		24,931	23
24		DURO-LAST ROOF SYSTEM.		5/15/2001	40,846	1,634	25	1,634		26,414	24
25		DONATION OF NURSE		10/1/2001	6,594	110	15	110		6,594	25
26		BOOSTER PUMP		12/31/2001	4,837	134	15	134		4,837	26
27		NEW HEAT EXCHANGER,INDUCE		9/20/2002	2,818	188	15	188		2,787	27
28		REMODELING PROJECT		6/30/2003	3,541		10			3,541	28
29		New flooring in 2 rooms		4/10/2004	2,576		7			2,576	29
30		therapy room/spa		11/30/2004	198,856	7,954	25	7,954		100,091	30
31		Water heater (75 gallon)		6/30/2006	6,376		10			6,376	31
32		HVAC unit for B wing		12/19/2006	7,600	380	10	380		7,600	32
33		Rooftop hvac unit		4/24/2008	3,973	397	10	397		3,642	33
34		Induct air purifiers (12)		12/7/2009	3,912	391	10	391		2,967	34
35		A.O. Smith water heater		8/17/2010	7,019	702	10	702		4,796	35
36		Sentronic door closers (2) f		6/23/2011	3,025	303	10	303		1,815	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Walter Lawson Childrens Home

0035469

Report Period Beginning:

07/01/2016 Ending: 06/30/2017

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Remodel C wing bathing room	12/16/2011	\$ 10,848	\$ 723	15	\$ 723	\$	\$ 3,978	37
38	Rpl roof and ceiling in main	1/20/2012	5,450	545	10	545		2,952	38
39	Kitchen & dining room remode	3/9/2012	19,090	1,273	15	1,273		6,788	39
40	West side siding, maint. sho	4/18/2012	4,929	493	10	493		2,547	40
41	Exterior lights, interior re	7/20/2012	3,304	330	10	330		1,625	41
42	Roof top units (2)	11/19/2012	12,680	1,268	10	1,268		5,812	42
43	Pipe Repair/Kitchen Floor Re	9/1/2014	3,100	310	10	310		878	43
44	Replace Rooftop Heating & Co	11/14/2014	6,291	629	10	629		1,678	44
45	Water Conditioners	2/16/2015	10,360	1,036	10	1,036		2,417	45
46	Radiator Assembly	3/19/2015	3,856	386	10	386		868	46
47	Concrete/Drainage Work	9/21/2015	15,060	1,506	10	1,506		2,636	47
48	Masonry Work	10/29/2015	2,550	255	10	255		425	48
49	Water Heater	11/18/2015	10,850	1,085	10	1,085		1,718	49
50	Wireless Emergency Call Syst	9/8/2016	17,793	1,483	10	1,483		1,483	50
51	Door Annunciator	9/8/2016	4,817	401	10	401		401	51
52	Access Control System	9/8/2016	5,068	422	10	422		422	52
53	Transfer Swtich	11/9/2016	4,712	314	10	314		314	53
54	Water Line Vacuum Breaker	11/16/2016	2,695	157	10	157		157	54
55	Power Strips	5/19/2017	5,610	47	10	47		47	55
56	BLACKTOP DRIVEWAY	11/24/1993	10,130		10			10,130	56
57	STRIP/SEAL NORTH PARKING	9/25/1995	3,382		10			3,382	57
58	PARKING LOT	9/22/1997	9,898		10			9,898	58
59	FENCE ON BACK LOT	10/7/1997	5,680		10			5,680	59
60	BLACKTOP NEW PARKING,DRIV	7/9/1998	9,752		10			9,752	60
61	REPLACE CONCRETE AT PAVIL	9/15/2000	2,700		15			2,700	61
62	Drywell	11/12/2008	12,588	629	20	629		5,455	62
63	Concrete gazebo floor & walk	5/11/2012	10,121	1,012	10	1,012		5,229	63
64	2 F2900 Controllers and Resi	2/25/2004	5,880		7			5,880	64
65	INSTALL SUMP PUMP & MANHO	10/19/1994	3,200		10			3,200	65
66	WATER BOOSTER SYS REPLACE	1/30/1995	6,941		10			6,941	66
67	INSTALL NEW MIXING VALVE	4/26/1996	2,960		10			2,960	67
68									68
69	Day Training/Education Assets Disallowed (See 5A)			(117,556)		(117,556)			69
70	TOTAL (lines 4 thru 69)		\$ 7,322,476	\$ 65,547		\$ 65,547	\$	\$ 3,487,831	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	\$ 78,431	\$ 14,311	\$ 14,311	\$	3-7	\$ 42,528	71
72	Current Year Purchases	31,062	4,099	4,099		5-7	4,099	72
73	Fully Depreciated Assets	661,061	3,635	3,635		3-10	661,061	73
74	Depr Exp - Rel Pty Alloc Sch VIII		2,101	2,101				74
75	TOTALS	\$ 770,554	\$ 24,146	\$ 24,146	\$		\$ 707,688	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	\$ 7,456	\$ 7,456	\$	5	\$ 40,670	76
77										77
78										78
79										79
80	TOTALS			\$ 40,670	\$ 7,456	\$ 7,456	\$		\$ 40,670	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)	\$ 8,818,128	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 97,149	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 97,149	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)	\$ 4,236,189	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	\$ 51,528	\$	\$ 51,528	86
87	Assets below IL Capital Threshold	386,753	19,536	306,535	87
88	Other Assets Disallowed	285,913	14,296	281,148	88
89					89
90					90
91	TOTALS	\$ 724,194	\$ 33,832	\$ 639,211	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

Facility Name & ID Number Walter Lawson Childrens Home

0035469

Report Period Beginning: 07/01/2016

Ending: 06/30/2017

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Not Applicable - Facility Leased from 100% Commonly-owned Related Party (See Sch VII)

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

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	Corp Grp Office Allocation		N/A	12/1/2011	7,508	10	10	6
7	TOTAL				\$ 7,508			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.	<u>6/30/2018</u>	\$ <u>Corp Alloc Amt</u>
13.	<u>6/30/2019</u>	\$ <u>Corp Alloc Amt</u>
14.	<u>6/30/2020</u>	\$ <u>Corp Alloc Amt</u>

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 5,173 Description: Postage Meter/Mail Equip: \$2,022; Short Term Medical Equip: \$1,880

(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.

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? <input checked="" type="checkbox"/> YES <input 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. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>50</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>80</u></p>
----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		802		802
3	Classroom Wages (a)		13,775		13,775
4	Clinical Wages (b)		22,040		22,040
5	In-House Trainer Wages (c)		5,938		5,938
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 42,555	\$	\$ 42,555
10	SUM OF line 9, col. 1 and 2 (e)	\$	42,555		

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	29
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	29

- (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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$				1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		552	38,623		552	38,623	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.1	2128 hrs	82,422				2,128	82,422	4
5	Physician Care		visits							5
6	Dental Care	39.3	visits		12	600		12	600	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39.3	# of prescrpts		64	4,226		64	4,226	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			\$ 82,422	628	\$ 43,449	\$	2,756	\$ 125,871	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **06/30/2017**

(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	\$ 1,000	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>33,625</u>)	863,981	863,981	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	(44,624)	(20,038)	6
7	Other Prepaid Expenses	51,513	51,513	7
8	Accounts Receivable (owners or related parties)	7,866,516	7,905,107	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 8,737,886	\$ 8,801,563	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		7,744,099	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost		1,113,797	16
17	Accumulated Depreciation (book methods)		(4,875,400)	17
18	Deferred Charges		169,792	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		390,491	21
22	Other Long-Term Assets (spe CIP)			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	\$ 5,488,338	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,999,017	\$ 14,289,901	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 217,942	\$ 214,522	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		184,072	29
30	Accrued Salaries Payable	498,298	498,298	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,674	10,674	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		13,763	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Intercompany payables</u>			36
37	<u>Rounding</u>	2	4	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 726,916	\$ 921,333	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,333,029	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)	\$	\$ 6,333,029	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 726,916	\$ 7,254,362	46
47	TOTAL EQUITY(page 18, line 24)	\$ 8,272,101	\$ 7,035,539	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,999,017	\$ 14,289,901	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 7,164,667	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 7,164,667	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,107,434	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)	\$ 1,107,434	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)	\$ 8,272,101	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Walter Lawson Childrens Home

0035469

Report Period Beginning: 07/01/2016

Ending: 06/30/2017

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	\$ 6,912,535	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,912,535	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	1,371,144	9
10	Other Government Grants	107,671	10
11	CNA Training Reimbursements	42,555	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)	\$ 1,521,370	23
D. Non-Operating Revenue			
24	Contributions	142,018	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 142,018	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)	206	27
28	Day Training	960,340	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 960,546	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,536,469	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	952,031	31
32	Health Care	3,361,103	32
33	General Administration	1,935,356	33
B. Capital Expense			
34	Ownership	563,766	34
C. Ancillary Expense			
35	Special Cost Centers	1,199,327	35
36	Provider Participation Fee	417,452	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,429,035	40
41	Income before Income Taxes (line 30 minus line 40)**	1,107,434	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,107,434	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 6,912,535	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)	\$ 6,912,535	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:

07/01/2016

Ending:

06/30/2017

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	1,895	2,074	\$ 151,729	\$ 73.16	1
2	Assistant Director of Nursing					2
3	Registered Nurses	21,401	23,459	751,809	32.05	3
4	Licensed Practical Nurses	16,692	18,652	656,587	35.20	4
5	CNAs & Orderlies	98,472	106,484	1,300,864	12.22	5
6	CNA Trainees					6
7	Licensed Therapist	1,936	2,129	82,423	38.71	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,978	2,221	37,698	16.97	9
10	Activity Assistants	3,969	4,205	37,024	8.80	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,915	2,060	40,895	19.85	13
14	Head Cook	5,610	6,165	81,450	13.21	14
15	Cook Helpers/Assistants	2,047	2,112	20,045	9.49	15
16	Dishwashers					16
17	Maintenance Workers	3,733	3,995	60,888	15.24	17
18	Housekeepers	15,275	16,707	197,950	11.85	18
19	Laundry	7,705	8,189	81,315	9.93	19
20	Administrator	1,966	2,148	129,664	60.36	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,786	5,346	109,084	20.40	24
25	Vocational Instruction	57,740	62,655	1,105,712	17.65	25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	247,120	268,601	\$ 4,845,137 *	\$ 18.04	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	295	\$ 12,158	1.3	35
36	Medical Director	N/A	13,000	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48	Note: Medical Dir paid flat fee, not hourly				48
49	TOTAL (lines 35 - 48)	295	\$ 25,158		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: 07/01/2016 Ending: 06/30/2017

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

DATE	DESCRIPTION	Amount
1 Legal Fees detail for SCH XIX-C		
8/5/2016	Baker, Donelson, Bearman, Caldwell & Berkowit	70.00
8/24/2016	SmithAmundsen	575.00
8/31/2016	Baker, Donelson, Bearman, Caldwell & Berkowit	156.16
10/31/2016	Baker, Donelson, Bearman, Caldwell & Berkowit	1,063.06
12/31/2016	Baker, Donelson, Bearman, Caldwell & Berkowit	197.33
1/31/2017	CT Corporation	119.33
3/6/2017	Stoll-Keenon-Ogden PLLC	79.84
7/31/2016	In-House Counsel Legal Fees	802.87
8/31/2016	In-House Counsel Legal Fees	876.38
9/30/2016	In-House Counsel Legal Fees	855.33
10/31/2016	In-House Counsel Legal Fees	641.65
11/30/2016	In-House Counsel Legal Fees	757.30
12/31/2016	In-House Counsel Legal Fees	732.08
1/31/2017	In-House Counsel Legal Fees	947.13
2/28/2017	In-House Counsel Legal Fees	779.79
3/31/2017	In-House Counsel Legal Fees	851.49
4/30/2017	In-House Counsel Legal Fees	761.33
5/31/2017	In-House Counsel Legal Fees	857.40
6/30/2017	In-House Counsel Legal Fees	736.50
		\$ 11,860

See Schedule VI for adjustment for unallowable portion.

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	265	24.3
Wynell Prince Eakle, Regional A/R	A 7	24.3
Katie Johnson, Education, in-state travel	A 80	24.3
Corporate/Group travel allocation of operations personnel	1,639	24.3
In-state business meals	A 533	24.3
	<u>2,523</u>	
<u>1 Out of State Travel Detail</u>		
Melissa Thornbloom, Executive Director	A 559	24.3
	<u>559</u>	
Line 24 Column 4 Total:	<u>3,082</u>	0
Line 24 Column 7 Adjustment - Corporate/Home Office Alloc:	23,064	
<i>Unallowable Amounts above removed through SCH 5 Adjustments:</i>		
A Non-care & out-of-state related amounts noted above:	(1,178)	
Allocation for non-care-related Education and Day Training (See Pg 11.2 & 5A)	(394)	
Line 24 Column 8 Total:	<u>24,574</u>	0

Facility Name & ID Number Walter Lawson Childrens Home# 0035469Report Period Beginning: 07/01/2016Ending: 06/30/2017**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, \$4,155 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? 7 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 94,520 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 417,452
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. \$ 107,671
- (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