

		FOR BHF USE					

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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

I. IDPH License ID Number: 0035469

Facility Name: Walter Lawson Childrens Home

Address: 1820 Walter Lawsn Dr Loves Park 61111
Number City Zip Code

County: Winnebago

Telephone Number: (815) 633-6636 Fax # (815) 633-6387

HFS ID Number:

Date of Initial License for Current Owners: 8/15/1989

Type of Ownership:

☒	VOLUNTARY, NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL
☒	Charitable Corp.	☐	Individual	☐	State
☐	Trust	☐	Partnership	☐	County
IRS Exemption Code	501(c)(3)	☐	Corporation	☐	Other
		☐	"Sub-S" Corp.		
		☐	Limited Liability Co.		
		☐	Trust		
		☐	Other		

In the event there are further questions about this report, please contact:
Name: Chris Louder Telephone Number: (615) 917-4020
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/2024 to 6/30/2025 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider	(Signed)		(Date)
	(Type or Print Name)	Chris Louder	
	(Title)	VP of Finance - Manager (HutsonWood)	
Paid Preparer	(Signed)		(Date)
	(Print Name and Title)	Eric Neidig Partner	
	(Firm Name & Address)	Bradley Associates 201 S. Capitol Ave. Suite 700, Indianapolis, IN 46225	
	(Telephone)	(317) 237-5500	Fax # (317) 237-5503
	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 2200 Churchill Rd. Springfield, IL 62702-3406		
	Phone # (217) 782-1630		

Facility Name & ID Number Walter Lawson Childrens Home # 0035469 Report Period Beginning: 7/1/2024 Ending: 6/30/2025

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	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF									8
9	SNF/PED	28,726							28,726	9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13

D. How many bed reserve days during this year were paid by the Department?
301 (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 8/15/1989

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 8/15/1989 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☐ NO ☒ If YES, enter certified beds.
number of certified beds

Medicare Intermediary N/A

IV. ACCOUNTING BASIS
ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

14	TOTALS	28,726						28,726	14
----	--------	--------	--	--	--	--	--	--------	----

C. Percent Occupancy. (Column 9, line 14 divided by total licensed
bed days on column 4, line 7.)

79.50%

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

Tax Year: 6/30/2025 Fiscal Year: 6/30/2025

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

STATE OF ILLINOIS

Page 3

Facility Name & ID Number

Walter Lawson Childrens Home

0035469

Report Period Beginning:

7/1/2024

Ending:

6/30/2025

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	230,419	17,915	17,263	265,597		265,597	(99,220)	166,377			1
2	Food Purchase		291,237		291,237		291,237	(109,197)	182,040			2
3	Housekeeping	272,323	38,327		310,650		310,650	(117,829)	192,821			3
4	Laundry	122,783	3,277	2,573	128,633	0	128,633	0	128,633			4
5	Heat and Other Utilities			123,764	123,764		123,764	(49,638)	74,126			5
6	Maintenance	80,302	16,765	62,819	159,886		159,886	(60,639)	99,247			6
7	Other (specify):*				0		0	0	0			7
8	TOTAL General Services	705,827	367,521	206,419	1,279,767	0	1,279,767	(436,523)	843,244			8
	B. Health Care and Programs											
9	Medical Director			13,000	13,000		13,000	0	13,000			9
10	Nursing and Medical Records	3,601,595	339,139	352,093	4,292,827		4,292,827	(27,573)	4,265,254			10
10a	Therapy	146,912	929	32,013	179,854		179,854	(89,927)	89,927			10a
11	Activities	100,507	765		101,272		101,272	0	101,272			11
12	Social Services				0		0	0	0			12
13	CNA Training				0		0	0	0			13
14	Program Transportation				0		0	0	0			14
15	Other (specify):*				0		0	0	0			15
16	TOTAL Health Care and Programs	3,849,014	340,833	397,106	4,586,953	0	4,586,953	(117,500)	4,469,453			16
	C. General Administration											
17	Administrative	181,557	122		181,679		181,679	(47,821)	133,858			17
18	Directors Fees			94,440	94,440		94,440	(24,858)	69,582			18
19	Professional Services			854,877	854,877		854,877	(324,803)	530,074			19
20	Dues, Fees, Subscriptions & Promotions			26,351	26,351	(2,057)	24,294	(12,087)	12,207			20
21	Clerical & General Office Expenses	108,095	6,940	101,281	216,316	2,057	218,373	(78,132)	140,241			21
22	Employee Benefits & Payroll Taxes			1,316,360	1,316,360		1,316,360	(387,660)	928,700			22
23	Inservice Training & Education			18,803	18,803		18,803	(5,961)	12,842			23
24	Travel and Seminar			3,171	3,171		3,171	(2,259)	912			24
25	Other Admin. Staff Transportation				0		0	0	0			25
26	Insurance-Prop.Liab.Malpractice			138,430	138,430		138,430	(1,177)	137,253			26
27	Other (specify):*				0		0	0	0			27
28	TOTAL General Administration	289,652	7,062	2,553,713	2,850,427	0	2,850,427	(884,758)	1,965,669			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,844,493	715,416	3,157,238	8,717,147	0	8,717,147	(1,438,781)	7,278,366			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.

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				0		0	349,075	349,075			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest			86	86		86	129,880	129,966			32
33	Real Estate Taxes				0		0	0	0			33
34	Rent-Facility & Grounds			516,841	516,841		516,841	(516,841)	0			34
35	Rent-Equipment & Vehicles			17,237	17,237		17,237	(2,558)	14,679			35
36	Other (specify):*				0		0	25,028	25,028			36
37	TOTAL Ownership			534,164	534,164	0	534,164	(15,416)	518,748			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		27,384	4,984	32,368		32,368	0	32,368			39
40	Barber and Beauty Shops		36		36		36	0	36			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			756,336	756,336		756,336	0	756,336			42
43	Other (specify):* DT/EDU	1,485,579	4,456	1,167	1,491,202		1,491,202	(1,488,150)	3,052			43
44	TOTAL Special Cost Centers	1,485,579	31,876	762,487	2,279,942	0	2,279,942	(1,488,150)	791,792			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,330,072	747,292	4,453,889	11,531,253	0	11,531,253	(2,942,347)	8,588,906			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 Attendee	Title of Attendee	Expense Amount
1 Relias Learning	All Employees	Various	16,439
2 American Red Cross - CPR Training	Various	Various	812
3 Proficio Conference	Katie Johnson	Education Director	472
4 Infection Prevention training	McKenzie Martin	ADON	160
5 American Red Cross - CPR Training	Various	Various	320
6 Tuition Reimbursement	Holly Pietrzak	Education - Teacher	300 @
7 Tuition Reimbursement	Holly Pietrzak	Education - Teacher	300 @
Line 23 Column 4 Total			18,803

Non-Allowable Amounts Above Removed through Schedule 5 Adjustments: Line 23 Column 7 Adjustments

Non-Care Related Amount Above	(600) @
Allocation for Non-Care Related Education and Day Training (see Page 5A & 11.1)	(5,361)
Line 23 Column 7 Total	(5,961)

Line 23 Column 8 Total

12,842

Description	Increase/Decrease	Schedule V Line
1 Reclass dues that were not professional in nature		
Clerical & General Office Expenses	2,057	21
Dues, Fees, Subscriptions & Promotions	(2,057)	20

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	\$ (1,488,150)	43	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(4,341)	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	(541)	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	43,691	19		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(4,723)	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	(1,355,401)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,809,465)		\$ 0	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)	(132,882)	19, 34	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (132,882)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (2,942,347)		37

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

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

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

BHF USE ONLY									
48		49		50		51		52	

Walter Lawson Childrens Home

	ID#	0035469
Report Period Beginning:		7/1/2024
Ending:		6/30/2025

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Political Action Committee Payments	\$ (3,004)	20	1
2	Non-Care Portion of Travel	(1,878)	24	2
3	Non-Allowable Portion of Inservice Training	(600)	23	3
4	Vendor Discounts	(279)	21	4
5	Medical Supply Rebates (DSSI & Medline)	(10,399)	10	5
6	Food Supply Rebates (GFS)	(635)	2	6
7	Non-Allowable Day Trng EDU Alloc - Dietary	(99,220)	1	7
8	Non-Allowable Day Trng EDU Alloc - Good	(108,562)	2	8
9	Non-Allowable Day Trng EDU Alloc - Housekeeping	(117,829)	3	9
10	Non-Allowable Day Trng EDU Alloc - Utilities	(45,297)	5	10
11	Non-Allowable Day Trng EDU Alloc - Maintenance	(60,639)	6	11
12	Non-Allowable Day Trng EDU Alloc - Therapy	(89,927)	10a	12
13	Non-Allowable Day Trng EDU Alloc - Admin	(47,821)	17	13
14	Non-Allowable Day Trng EDU Alloc - Directors	(24,858)	18	14
15	Non-Allowable Day Trng EDU Alloc - Prof Svcs	(185,505)	19	15
16	Non-Allowable Day Trng EDU Alloc - Dues/Fees	(4,360)	20	16
17	Non-Allowable Day Trng EDU Alloc - Clerical	(50,101)	21	17
18	Non-Allowable Day Trng EDU Alloc - Benefits	(387,660)	22	18
19	Non-Allowable Day Trng EDU Alloc - Inservice Training	(5,361)	23	19
20	Non-Allowable Day Trng EDU Alloc - Travel/Seminar	(381)	24	20
21	Non-Allowable Day Trng EDU Alloc - Insurance	(52,506)	26	21
22	Non-Allowable Day Trng EDU Alloc - Equip/Vehicle Re	(2,558)	35	22
23	Interest Expense - Late Fees	(86)	32	23

24	Non-Allowable Depreciation Expense	(11,009)	30	24
25	Flowers	(272)	21	25
26	Goodwill Amortization	(26,113)	21	26
27	Patient Replacements	(1,367)	21	27
28	Marketing	(17,174)	10	28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,355,401)		49

Summary A

6/30/2025

[illegible]

[illegible]

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	Loves Park Facility C	Loves Park, IL	Property Co.
		Swann Special Care Center	Champaign, IL	Hoosier Care Investm	Nashville, TN	NFP Affiliated Co.
		Exceptional Living of Brazil	Brazil, IN	HHSS Management	Nashville, TN	Management Co.
		Richland Bean-Blossom Healthcare	Ellettsville, IN			
		Vernon Health & Rehabilitation	Wabash, IN			
		Emerald Spring Hill	Nashville, TN			

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	18	Group Mgmt/Dir Fees	\$ 94,440	Hoosier Care Investments	100.00%	\$ 94,440	\$	1
2	V				Note: See Schedule VII Section C for description.				2
3	V	19	Management Fees	828,930	HHSS Management	100.00%	635,126	(193,804)	3
4	V								4
5	V								5
6	V								6
7	V		Please see continued discolsure and detail of adjustments on PG6A.						7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 923,370			\$ 729,566	\$ * (193,804)	14

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	Related Party Building/Equip. Rental	\$ 516,841	Loves Park Facility Company, LLC	100.00%	\$	\$ (516,841)	15
16	V				This facility company is under 100% common ownership				16
17	V				with WLCH, and therefore the rent paid to the facility				17
18	V				company has been removed from this report and the				18
19	V				actual expenses of the facility company have been				19
20	V				added here:				20
21	V	30	Related Party Depreciation		Loves Park Facility Company, LLC		360,084	360,084	21
22	V	32	Related Party Interest (Net)		Loves Park Facility Company, LLC		123,810	123,810	22
23	V	32	Related Party Amortization of Debt Cost		Loves Park Facility Company, LLC		6,697	6,697	23
24	V	26	Related Party Insurance		Loves Park Facility Company, LLC		51,329	51,329	24
25	V	19	Related Party Accounting Fees		Loves Park Facility Company, LLC		10,815	10,815	25
26	V	36	Related Party Mortgage Insurance		Loves Park Facility Company, LLC		25,028	25,028	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 516,841			\$ 577,763	\$ * 60,922	39

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

VII. RELATED PARTIES

A. (Continued)

Enter below the names of ALL related nursing homes and related organizations (parties) as defined in the instructions.

	1		2		3			
	RELATED NURSING HOMES		RELATED NURSING HOMES		OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
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30								30

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	0.00					\$		1
2	Jim Ridenour	Board Member	Governance	0.00							2
3	Jo Anne Corbitt	Board Member	Governance	0.00							3
4	Douglass Smith	Board Member	Governance	0.00							4
5	Laura Hawken	Board Member	Governance	0.00							5
6	Stephen Wood Jr	Board Member	Governance	0.00							6
7	Chris Hodges	Board Member	Governance	0.00							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 Board of HCI affiliated										8
9	facilities, WLCH being one of many. Therefore no Board Fees or compensation paid directly by WLCH to the Directors, but rather the fees paid by WLCH to HCI are										9
10	combined with similar fees paid by other facilities, for HCI to provided governance and managerial oversight, including payment by HCI to Board members of each legal										10
11	entity. Fees paid by other IL facilities are shown on Page 7.1 The entire amount of fees included on this report, grouped on Line 18, is disclosed here at actual cost to the										11
12	facility:								94,440	18.3	12
13								TOTAL	\$ 94,440		13

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

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

VII. RELATED PARTIES (continued)

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

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

Amounts Paid for Directors/Administration Fees by Other Nursing Homes

Walter Lawson Children's Home	94,440
Swann Special Care Center	116,976
Exceptional Care & Training Center	80,364

Facility Name & ID Number Walter Lawson Childrens Home # 0035469 Report Period Beginning: 7/1/2024 Ending: 5/30/2025

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 _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

	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						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	LP Mortgage HUD Loan		X	Facility Purchase Financing	\$28,956.15	11/1/12	\$ 7,290,000	\$ 4,905,044	11/1/42	0.0254	\$ 129,966	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$28,956.15		\$ 7,290,000	\$ 4,905,044			\$ 129,966	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$ 0	\$ 0			\$ 0	14	
15	TOTALS (line 9+line14)						\$ 7,290,000	\$ 4,905,044			\$ 129,966	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 25,028 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

1. Real Estate Tax accrual used on 2024 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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).			\$0	3
4. Real Estate Tax accrual used for 2025 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.			\$0	7
Assessed Value from Real Estate Tax Bill: 2024 8				
Real Estate Tax Bill for Calendar Year: 2020 9				
2021 10				
2022 11				
2023 12				
2024 13				
Note: This facility became tax exempt as of 1/1/1996.				
			14	FROM R. E. TAX STATEMENT FOR 2024 \$ 14
			15	PLUS APPEAL COST FROM LINE 5 \$ 15
			16	LESS REFUND FROM LINE 6 \$ 16
			17	AMOUNT TO USE FOR RATE CALCULATION \$ 17

- 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.

2024 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 2024 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 2024.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	<u>TAX EXEMPT</u>		\$	\$
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$

8.			\$		\$	
9.			\$		\$	
10.			\$		\$	
TOTALS			\$	0.00	\$	0.00

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?

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 copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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:

47,999

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 Development Day Training Program and Special Education Programs; cost removal adjustments and allocations to remove associated costs shown on Sch V. See PG11.1 for further detail.

F. List the bed capacity for the building if it differs from the licensed total.

G. Have you properly capitalized all major repairs and equipment purchases?

Yes

H. Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

I. Are you presently operating under a sublease agreement?

No

J. 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.

K. 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.

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

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 Development 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, rent, and occupancy costs, have been grouped to line 43 of Schedule V, "Other Costs Centers", and are removed via adjustment on Schedule VI, line 1.

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 operation programs are identified, segregated, and reported each year in conjunction with required cost report filings to the Illinois Purchased Care Review Board for the Education program. The percentage of costs identified for each program from the most recent ILPCRB port 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 allocated employee benefits and payroll taxes. Hours of operation of each program are utilized to allocate certain administrative, overhead, and support services, and other allocation bases are utilized for applicable shared costs. 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	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		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	\$	\$ 2,652,729	4
5	6			2008	3,659,316	91,483	40	91,483		1,570,456	5
6											6
7											7
8											8
	Improvement Type**										
9	CARRIER HEAT/AIR CONDITIO			7/1/1990	17,400	0	5	0		17,400	9
10	BLACKTOP DRIVEWAY			11/24/1993	10,130	0	10	0		10,130	10
11	INSTALL SUMP PUMP & MANHO			10/19/1994	3,200	0	10	0		3,200	11
12	WATER BOOSTER SYS REPLACE			1/30/1995	6,941	0	10	0		6,941	12
13	STRIP/SEAL NORTH PARKING			9/25/1995	3,382	0	10	0		3,382	13
14	INSTALL NEW WINDOWS			12/20/1995	2,588	0	10	0		2,588	14
15	TILE KITCHEN FLOOR			1/31/1996	5,187	0	10	0		5,187	15
16	INSTALL WATER HEATER			3/19/1996	4,981	0	10	0		4,981	16
17	INSTALL NEW MIXING VALVE			4/26/1996	2,960	0	10	0		2,960	17
18	INSTALL WATER HEATER			2/11/1997	6,014	0	10	0		6,014	18
19	SHOWER TROLLEY			3/11/1997	10,924	0	10	0		10,924	19
20	INSTALL A/C ROOF-TOP UNIT			7/16/1997	2,975	0	10	0		2,975	20
21	PARKING LOT			9/22/1997	9,898	0	10	0		9,898	21
22	FENCE ON BACK LOT			10/7/1997	5,680	0	10	0		5,680	22
23	INSTALL EMERGENCY GENERAT			1/12/1998	85,329	0	10	0		85,329	23
24	BLACKTOP NEW PARKING,DRIV			7/9/1998	9,752	0	10	0		9,752	24
25	INSTALL			11/29/1999	3,265	0	15	0		3,265	25
26	PARTIAL PMT-TELEPHONE SYS			3/27/2000	6,528	0	10	0		6,528	26
27	PARTIAL PMT-TELEPHONE SYS			3/27/2000	3,264	0	10	0		3,264	27
28	REPLACE CONCRETE AT PAVIL			9/15/2000	2,700	0	15	0		2,700	28
29	FIRE SPRINKLER SYSTEM.			1/15/2001	37,774	1,511	25	1,511		36,893	29
30	DONATION OF NURSE			10/1/2001	6,594	0	15	0		6,594	30
31	BOOSTER PUMP			12/31/2001	4,837	0	15	0		4,837	31
32	NEW HEAT EXCHANGER,INDUCE			9/20/2002	2,818	0	15	0		2,818	32
33	REMODELING PROJECT			6/30/2003	3,541	0	10	0		3,541	33
34	2 F2900 Controllors and Resin			2/25/2004	5,880	0	7	0		5,880	34
35	New flooring in 2 rooms			4/10/2004	2,576	0	7	0		2,576	35
36	therapy room/spa			11/30/2004	198,856	7,954	25	7,954		163,725	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

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	Water heater (75 gallon)	6/30/2006	\$ 6,376	\$ 0	10	\$ 0	\$	\$ 6,376	37
38	HVAC unit for B wing	12/19/2006	7,600	0	10	0		7,600	38
39	Rooftop hvac unit	4/24/2008	3,973	0	10	0		3,973	39
40	Drywell	11/12/2008	12,588	629	20	629		10,438	40
41	Induct air purifiers (12)	12/7/2009	3,912	0	10	0		3,912	41
42	A.O. Smith water heater	8/17/2010	7,019	0	10	0		7,019	42
43	Sentronic door closers (2) for old bldg	6/23/2011	3,025	0	10	0		3,025	43
44	Remodel C wing bathing room	12/16/2011	10,848	723	15	723		9,763	44
45	Kitchen & dining room remodeling	3/9/2012	19,090	1,273	15	1,273		16,863	45
46	West side siding, maint. shop drywall	4/18/2012	4,929	0	10	0		4,929	46
47	Concrete gazebo floor & walks	5/11/2012	10,121	0	10	0		10,121	47
48	Exterior lights, interior recep, exit li	7/20/2012	3,304	0	10	0		3,304	48
49	Roof top units (2)	11/19/2012	12,680	0	10	0		12,680	49
50	Pipe Repair/Kitchen Floor Replacement	9/1/2014	3,100	77	10	77		3,100	50
51	Replace Rooftop Heating & Cooling Unit	11/14/2014	6,291	262	10	262		6,291	51
52	Water Conditioners	2/16/2015	10,360	691	10	691		10,360	52
53	Radiator Assembly	3/19/2015	3,856	289	10	289		3,856	53
54	Concrete/Drainage Work	9/21/2015	15,060	1,506	10	1,506		14,684	54
55	Masonrv Work	10/29/2015	2,550	255	10	255		2,465	55
56	Water Heater	11/18/2015	10,850	1,085	10	1,085		10,398	56
57	Wireless Emergency Call System	9/8/2016	17,793	1,779	10	1,779		15,569	57
58	Access Control System	9/8/2016	5,068	507	10	507		4,435	58
59	Door Annunciator	9/8/2016	4,817	482	10	482		4,215	59
60	Transfer Swtich	11/9/2016	4,712	471	10	471		4,044	60
61	Water Line Vacuum Breaker	11/16/2016	2,695	270	10	270		2,313	61
62	Power Strips	5/19/2017	5,610	561	10	561		4,535	62
63	HVAC Unit	7/24/2017	6,665	666	10	666		5,277	63
64	Metal Doors Replaced	9/11/2017	3,750	375	10	375		2,906	64
65	Rooftop HVAC Unit	10/13/2017	7,680	768	10	768		5,888	65
66	Roof Deposit	11/17/2017	64,500	6,450	10	6,450		48,913	66
67	HVAC Coil Replaced	12/7/2017	4,520	452	10	452		3,390	67
68	Roof	1/4/2018	161,898	16,190	10	16,190		120,074	68
69	Fiberglass Shower Panel	1/18/2018	2,901	290	10	290		2,151	69
70	TOTAL (lines 4 thru 69)		\$ 7,492,431	\$ 200,424		\$ 200,424	\$ 0	\$ 5,028,014	70

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

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	
1	Totals from Page 12A, Carried Forward		\$ 7,492,431	\$ 200,424		\$ 200,424	\$	\$ 5,028,014	1
2	Commerical Windows		5,450	545	10	545		3,860	2
3	Playground Equipment		2,860	286	10	286		1,931	3
4	install playground equipment		10,936	1,094	10	1,094		7,200	4
5	playground equipment		11,134	1,113	10	1,113		7,330	5
6	100 gallon water heater		10,757	1,076	10	1,076		7,082	6
7	2 new doors		9,382	938	10	938		6,177	7
8	Ceiling repairs		2,852	285	10	285		1,854	8
9	Celing repairs		3,097	310	10	310		2,013	9
10	2 ton roof top ptac unit		6,970	697	10	697		4,473	10
11	Mixing Valve		3,995	399	10	399		2,530	11
12	Waterline installation		3,288	329	10	329		2,028	12
13	Door for kitchen		2,550	255	10	255		1,573	13
14	New Pressure Valvue		4,108	411	10	411		2,431	14
15	Landscaping work - 50%		5,447	545	10	545		3,222	15
16	Concrete Wall - 50%		6,600	660	10	660		3,850	16
17	French drain installation		2,840	284	10	284		1,585	17
18	Concrete Slab		3,150	315	10	315		1,706	18
19	Bench installation		3,700	370	10	370		2,004	19
20	Playground project		7,952	795	10	795		4,307	20
21	Sensory wall and 2 benches		20,681	2,068	10	2,068		11,202	21
22	Painting of Exterior Walls Behind Building		3,800	697	10	697		3,800	22
23	New roof for Gazebo		5,300	530	10	530		2,473	23
24	Nursing Station (Counters, Electric, & Plumbing) and South Entrance Lobby (Floorin		48,371	2,418	10	2,418		7,457	24
25	Building Addition		1,570,158	52,339	40	52,339		157,016	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,247,809	\$ 269,183		\$ 269,183	\$ 0	\$ 5,277,118	34

**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	\$297,631	\$55,619	\$55,619	\$0	5-7	\$160,340	71
72	Current Year Purchases	48,863	3,764	3,764	0	5-7	3,764	72
73	Fully Depreciated Assets	832,363	5,377	5,377	0	3-10	832,363	73
74					0			74
75	TOTALS	\$1,178,858	\$64,760	\$64,760	\$0		\$996,467	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	2023 Ram ProMaster Van	2023	\$75,662	\$15,132	\$15,132	\$0	5	\$31,526	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$75,662	\$15,132	\$15,132	\$0		\$31,526	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)	\$11,186,756	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$349,075	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$349,075	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$0	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$6,305,111	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	\$0	\$51,528	86
87	Assets Below IL Capital Threshold	467,730	10,887	447,265	87
88	Other Assets Disallowed	285,913	0	285,913	88
89					89
90					90
91	TOTALS	\$805,172	\$10,887	\$784,707	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.**

XII. RENTAL COSTS

- A. Building and Fixed Equipment (See instructions.)
1. Name of Party Holding Lease: N/A - Facility and fixed equipment 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								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
- This amount was calculated by dividing the total amount to be amortized by the length of the lease.
9. Option to Buy: ☐ YES ☒ NO Terms: *

- B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)
15. Is Movable equipment rental included in building rental? ☒ YES ☐ NO
16. Rental Amount for movable equipment: \$ 17,237 Description: See Page 14.1

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:
- Beginning
- Ending
11. Rent to be paid in future years under the current rental agreement:
- | | Fiscal Year Ending | Annual Rent |
|-----|--------------------|-------------|
| 12. | /2026 | \$ |
| 13. | /2027 | \$ |
| 14. | /2028 | \$ |

* 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.

Exceptional Care & Training Center

Moveable Equipment Rental Detail

Description	Amount	Schedule V Line
1 Concentrator Rental	11,774	35
2 Compressors	4,227	35
3 Medline Pump	1,640	35
3 Misc Repayment	(404)	35
4		
5		
Line 35 Column 6 Total	17,237	

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1	
2	Licensed Speech and Language Development Therapist	10a.3	hrs			213	32,013		213	32,013	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	10a.1	2864 hrs	146,912					2,864	146,912	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Other (specify):										12
13	Other (specify):										13
14	TOTAL			\$ 146,912	213	\$ 32,013	\$	3,077	\$ 178,925	14	

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

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$1,989,726	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance20,000)	1,404,678		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	168,603		6
7	Other Prepaid Expenses	13,609		7
8	Accounts Receivable (owners or related parties)	2,570,995		8
9	Other(specify): Goodwill	182,792		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$6,330,403	\$0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	82,239		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$82,239	\$0	24

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$293,495	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	468,780		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Patient Trust Liability	82,239		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$844,514	\$0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$0	\$0	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$844,514	\$0	46

25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,412,642	\$ 0	25

47	TOTAL EQUITY(page 18, line 24)	\$ 5,568,128	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,412,642	\$ 0	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 6,641,317	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 6,641,317	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	5,047,925	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)	\$ 5,047,925	17
	B. Transfers (Itemize):		
18	Other Equity Withdrawals	(6,121,113)	18
19	Rounding	(1)	19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (6,121,114)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 5,568,128	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	\$ 12,981,307	1
2	Discounts and Allowances for all Levels	(4,144)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,977,163	3
	B. Ancillary Revenue		
4	Day Care	1,658,539	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,658,539	8
	C. Other Operating Revenue		
9	Payments for Education	1,864,902	9
10	Other Government Grants	66,717	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,931,619	23
	D. Non-Operating Revenue		
24	Contributions	0	24
25	Interest and Other Investment Income***	541	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 541	26
	E. Other Revenue (specify):****		

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,279,767	31
32	Health Care	4,586,953	32
33	General Administration	2,850,427	33
	B. Capital Expense		
34	Ownership	534,164	34
	C. Ancillary Expense		
35	Special Cost Centers	1,523,606	35
36	Provider Participation Fee	756,336	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,531,253	40
41	Income before Income Taxes (line 30 minus line 40)**	5,047,922	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 5,047,922	43

III. Net Inpatient Revenue detailed by Payer Source for each line			
44	Medicaid Fee for Service	\$ 12,981,307.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)		45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay		48
49	Medicare Part A		49
50	Other-(specify) Bad Debt	-4,144.00	50
51	Other-(specify)		51

27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Page 19.1	11,313	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 11,313	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 16,579,175	30

52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 12,977,163	56

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	
	E. Other Revenue (specify):****		
28.1	Refunds/Rebates	11,034	28.1
28.2	Vendor Discounts	134	28.2
28.3	Miscellaneous	40	28.3
28.4	Medical Records	105	28.4
	SUBTOTAL Other Revenue	\$ 11,313	

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	1,940	2,080	\$ 147,319	\$ 70.83	1
2	Assistant Director of Nursing	1,692	1,728	83,754	48.47	2
3	Registered Nurses	23,035	24,920	1,185,139	47.56	3
4	Licensed Practical Nurses	7,855	8,591	381,712	44.43	4
5	CNAs & Orderlies	70,370	74,726	1,783,484	23.87	5
6	CNA Trainees					6
7	Licensed Therapist	2,864	3,159	146,912	46.51	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,521	1,704	40,622	23.84	9
10	Activity Assistants	3,242	3,441	59,884	17.40	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,935	2,206	62,499	28.33	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,067	7,514	167,920	22.35	15
16	Dishwashers					16
17	Maintenance Workers	1,924	2,080	80,302	38.61	17
18	Housekeepers	12,440	13,517	272,323	20.15	18
19	Laundry	5,662	5,994	122,783	20.48	19
20	Administrator	1,849	2,080	181,557	87.29	20
21	Assistant Administrator					21
22	Other Administrative	3,628	3,971	108,096	27.22	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care Admin Scheduler	875	899	20,186	22.45	32
33	Other(specify) <u>EDU/DT</u>	47,325	52,098	1,485,578	28.52	33

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	287	\$ 12,931	1.3	35
36	Medical Director	Note	13,000	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Note	3,855	39.3	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) <u>ED Consultant</u>	5	625	43.3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	292	\$ 30,411		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	2,430	\$ 184,409	10.3	50
51	Licensed Practical Nurses	2,039	122,634	10.3	51
52	Certified Nurse Assistants/Aides	790	27,366	10.3	52
53	TOTAL (lines 50 - 52)	5,259	\$ 334,409		53

34	TOTAL (lines 1 - 33)	195,224	210,708	\$ 6,330,070 *	\$ 30.04	34
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* This total must agree with page 4, column 1, line 45.

** See instructions.

(For legal fee disclosure, see page 39 of instructions)	\$ 854,877		TOTAL line 24, col. 8)	\$ 912
		* Attach copy of IMRF notifications	**See instructions.	

XIX. SUPPORT SCHEDULES

Legal Fees Detail

Date	Vendor	Description	Amount
9/30/2024	Baker, Donelson, Bearman, Caldwell & Berkowitz PC	NRAI/IN & IL Statutory Rep, I	\$ 413
MULTIPLE	Baker, Donelson, Bearman, Caldwell & Berkowitz PC	FEMA Matters	\$ 454
8/6/2024	POLSINELLI PC	IL Medicaid Bed Hold Matter	\$ 1,305

2,172

See Schedule VI for adjustment for non-allowable portion.

XIX. SUPPORT SCHEDULES

Accounting Fees Detail

Date	Vendor	Description	Amount
7/31/2024	Bradley & Associates	Billing Prep Medicaid Cost report	\$ 1,850
8/31/2024	Bradley & Associates	Billing Prep Medicaid Cost report	\$ 2,000
9/30/2024	Bradley & Associates	Billing Prep Hoosier Care Education Report	\$ 757
9/30/2024	Bradley & Associates	Final Billing Prep for Medicaid Cost Report	\$ 850
10/31/2024	Bradley & Associates	Billing Prep Education Financial Report	\$ 500
12/31/2024	Bradley & Associates	Final Billing Prep Education Financial Report	\$ 225
7/12/2024	HHSS Management	First Installment for 990 preparation	\$ 350
9/17/2024	HHSS Management	Progress billing for 6/30/24 audit	\$ 4,200
10/15/2024	HHSS Management	Progress billing for 6/30/24 audit	\$ 2,250
11/15/2024	HHSS Management	2023 tax compliance HW Inc. 990 review	\$ 245
2/12/2025	HHSS Management	Progress billing for 2023 tax compliance service	\$ 1,085
6/3/2025	HHSS Management	Audit services for HW Health and Housing for	\$ 2,300
6/15/2025	HHSS Management	2023 tax compliance services	\$ 735
			<u>17,347</u>

Facility Name & ID Number Walter Lawson Childrens Home

0035469

Report Period Beginning: 7/1/2024

Ending: 6/30/2025

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below. Use the drop down list to identify the association.
- | Association Name | Amount |
|--|--------------------|
| <u>IL HEALTHCARE ASSOCIATION (IHCA)</u> | <u>5,456</u> |
| <u>Other, please specify INHAA / AHCA / National Quality</u> | <u>625</u> |
| | <u>6,081</u> Total |
- (3) List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.
- | | |
|--|--------------------|
| <u>IL HEALTHCARE ASSOCIATION (IHCA)</u> | <u>3,004</u> |
| <u>0</u> | |
| <u>Other, please specify INHAA / AHCA / National Quality</u> | |
| | <u>3,004</u> Total |
- (4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)
- | | |
|--|--------------------|
| <u>IL HEALTHCARE ASSOCIATION (IHCA)</u> | <u>8,460</u> |
| <u>0</u> | <u>0</u> |
| <u>Other, please specify INHAA / AHCA / National Quality</u> | <u>625</u> |
| | <u>0</u> |
| | <u>9,085</u> Total |
- (5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. \$ 104,162 Line 10
- (6) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (7) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 756,336
This amount is to be recorded on line 42 of Schedule V.

- (9) 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
- (10) 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 11.1. 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.
- (11) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ No Has any meal income been offset against related costs? No Indicate the amount. \$
- (12) 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. \$
- (13) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Crowe LLP
- (14) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (15) Has a schedule for the legal fees reported on the cost report been provided by the facility?

(8) 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.

See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.