

Facility Name & ID Number Walker Nursing Home

0021428 Report Period Beginning: 10/01/2012 Ending: 09/30/2013

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 N/A

	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	71	Skilled (SNF)	71	25,915	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	71	TOTALS	71	25,915	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		5,397	1,656	7,053	8
9	SNF/PED					9
10	ICF	10,870			10,870	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,870	5,397	1,656	17,923	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.16%

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

None (Do not include bed-hold days in Section B.)

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

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

None

F. Does the facility maintain a daily midnight census? Yes

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

YES NO

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

YES NO

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

Date started 01/01/1955

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

YES Date _____ NO

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

YES NO If YES, enter number of beds certified 71 and days of care provided 1,656

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 09/30/2013 Fiscal Year: 09/30/2013

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Walker Nursing Home

0021428

Report Period Beginning:

10/01/2012

Ending:

09/30/2013

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	113,366	346	4,928	118,640		118,640	118,640			1
2	Food Purchase		142,109		142,109		142,109	142,109			2
3	Housekeeping	45,685	7,942		53,627		53,627	53,627			3
4	Laundry	55,682	184		55,866		55,866	55,866			4
5	Heat and Other Utilities			55,868	55,868		55,868	55,868			5
6	Maintenance	46,787	16,933	27,700	91,420		91,420	91,420			6
7	Other (specify):*										7
8	TOTAL General Services	261,520	167,514	88,496	517,530		517,530	517,530			8
	B. Health Care and Programs										
9	Medical Director			8,400	8,400		8,400	8,400			9
10	Nursing and Medical Records	806,165	67,850	7,570	881,585		881,585	881,585			10
10a	Therapy			269,999	269,999		269,999	269,999			10a
11	Activities	21,268	3,823	5,100	30,191		30,191	30,191			11
12	Social Services	39,944			39,944		39,944	39,944			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Infection Control			10,644	10,644		10,644	10,644			15
16	TOTAL Health Care and Programs	867,377	71,673	301,713	1,240,763		1,240,763	1,240,763			16
	C. General Administration										
17	Administrative	121,722			121,722	4,000	125,722	125,722			17
18	Directors Fees										18
19	Professional Services			56,955	56,955		56,955	(17,135)	39,820		19
20	Dues, Fees, Subscriptions & Promotions			14,433	14,433		14,433	(5,367)	9,066		20
21	Clerical & General Office Expenses	46,749	9,563	23,727	80,039		80,039	80,039			21
22	Employee Benefits & Payroll Taxes			182,601	182,601	(4,000)	178,601	(1,325)	177,276		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,346	3,346		3,346	3,346			24
25	Other Admin. Staff Transportation			11,028	11,028		11,028	11,028			25
26	Insurance-Prop.Liab.Malpractice			36,524	36,524		36,524	36,524			26
27	Other (specify):*										27
28	TOTAL General Administration	168,471	9,563	328,614	506,648		506,648	(23,827)	482,821		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,297,368	248,750	718,823	2,264,941		2,264,941	(23,827)	2,241,114		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

STATE OF ILLINOIS

Page 3A

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/1/2012 Ending: 9/30/2013

<u>Travel & Seminar, Line 24 Col 3</u>	<u>Amount</u>
INAAA	95
Continuing Education Institute	129
Briggs Healthcare	20
Barnes & Noble (Pharmacy Handbooks)	122
INHAA Workshop (White)	125
CPR Course	65
IAPA	235
Point Click Care (A/R software training)	2,500
4 Dictionaries	20
SRAA	35
	<hr/>
	3,346
	<hr/> <hr/>
<u>Other Admin Staff Transportation</u>	
<u>Line 25, Col 3</u>	
Fuel	9,386
Vehicle Repairs	1,378
Lodging	145
License	119
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	11,028
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Walker Nursing Home

#0021428

Report Period Beginning:

10/01/2012

Ending:

09/30/2013

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			48,992	48,992		48,992	8,124	57,116			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			24,203	24,203		24,203		24,203			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			3,346	3,346		3,346		3,346			35
36	Other (specify):*											36
37	TOTAL Ownership			76,541	76,541		76,541	8,124	84,665			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		12,357		12,357		12,357		12,357			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			157,581	157,581		157,581		157,581			42
43	Other (specify):*			35,643	35,643		35,643	(35,643)				43
44	TOTAL Special Cost Centers		12,357	193,224	205,581		205,581	(35,643)	169,938			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,297,368	261,107	988,588	2,547,063		2,547,063	(51,346)	2,495,717			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/1/2012 Ending: 9/30/2013

<u>Other - Line 43, Column 3</u>	<u>Amount</u>
Contributions	160
Advertising	12,305
Entertainment	359
Non Deductible Expenses	96
State Replacement Tax	6,175
Sales Tax	458
Medicare Services	651
Labs - Medicare	11,903
Medical Supplies Medicare	3,536
	<hr/>
	35,643
	<hr/> <hr/>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Home

0021428

Report Period Beginning: 10/01/2012

Ending: 09/30/2013

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				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	8,124	30		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	(458)	43		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	(1,325)	22		17
18	Fines and Penalties				18
19	Entertainment	(359)	43		19
20	Contributions	(160)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(17,135)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(5,367)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(6,175)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(28,491)	43		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (51,346)		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (51,346)		37

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

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

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

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Walker Nursing Home

ID# 0021428

Report Period Beginning: 10/01/2012

Ending: 09/30/2013

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Advertising	\$ (12,305)	43	1
2	Non-Deductible Expenses	(96)	43	2
3	Medicare Services	(651)	43	3
4	Labs Medicare	(11,903)	43	4
5	Medical Supplies	(3,536)	43	5
6				6
7				7
8				8
9				9
10				10
11	SEE ACCOUNTANTS' COMPILATION REPORT			11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(28,491)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Walker Nursing Home

0021428

Report Period Beginning:

10/01/2012

Ending:

09/30/2013

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

	Operating Expenses	PAGES	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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(17,135)	0	0	0	0	0	0	0	0	0	0	(17,135)	19
20	Fees, Subscriptions & Promotions	(5,367)	0	0	0	0	0	0	0	0	0	0	(5,367)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(1,325)	0	0	0	0	0	0	0	0	0	0	(1,325)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(23,827)	0	(23,827)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(23,827)	0	(23,827)	29									

STATE OF ILLINOIS

Facility Name & ID Number Walker Nursing Home

0021428

Report Period Beginning:

10/01/2012 Ending:

Summary B

09/30/2013

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	8,124	0	0	0	0	0	0	0	0	0	0	8,124	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	8,124	0	0	0	0	0	0	0	0	0	0	8,124	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):*	(35,643)	0	0	0	0	0	0	0	0	0	0	(35,643)	43
44	TOTAL Special Cost Centers	(35,643)	0	0	0	0	0	0	0	0	0	0	(35,643)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(51,346)	0	0	0	0	0	0	0	0	0	0	(51,346)	45

Facility Name & ID Number

Walker Nursing Home

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Report Period Beginning:

10/01/2012

Ending:

09/30/2013

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
George W. White	50	N/A		N/A		
Mary Ann White	50	N/A		N/A		

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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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								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								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/01/2012 Ending: 09/30/2013

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	Mary Ann White	President	Co-Administrator	50.00	0	16	40.00	Salary	\$ 16,846	17(1)	1
2			Office Manager			24	60.00	Salary	25,269	21(1)	2
3											3
4	George W. White	Vice President	Co-Administrator	50.00	0	18	45.00	Salary	18,952	17(1)	4
5			Maintenance			22	55.00	Salary	23,163	6(1)	5
6											6
7	Bryan White	None	Asst. Admin	0.00	0	32	80.00	Salary	42,962	17(1)	7
8			Clerical			8	20.00	Salary	10,740	21(1)	8
9											9
10	Rachel White	None	Asst. Admin	0.00	0	26	80.00	Salary	42,962	17(1)	10
11			Clerical			6	20.00	Salary	10,740	21(1)	11
12											12
13								TOTAL	\$ 191,634		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Home

0021428

Report Period Beginning:

10/01/2012

Ending:

9/30/2013

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4			N/A						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

SEE ACCOUNTANTS' COMPILATION REPORT

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Walker Nursing Home COUNTY Cass

FACILITY IDPH LICENSE NUMBER 0021428

CONTACT PERSON REGARDING THIS REPORT Roger Hurst

TELEPHONE (217) 787-9700 FAX #: (217) 787-2719

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2012 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 2012.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>09-033-009-00</u>	<u>Lot</u>	\$ <u>521.32</u>	\$ <u>521.32</u>
2. <u>11-052-009-00</u>	<u>Lot</u>	\$ <u>447.94</u>	\$ <u>447.94</u>
3. <u>11-087-007-00</u>	<u>Lot</u>	\$ <u>23,503.46</u>	\$ <u>23,503.46</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. <u>SEE ACCOUNTANTS'</u>	_____	\$ _____	\$ _____
10. <u>COMPILATION REPORT</u>	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>24,472.72</u></u>	\$ <u><u>24,472.72</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 X 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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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.**

Nov. 8. 2013 9:41AM Walker Nursing Home
 CASS COUNTY
 MICKI WILSON TREASURER
 PO BOX 167
 VIRGINIA, IL 62691

PROPERTY NUMBER	No. 8367	COD P.	10	ABER
11-052-009-00	0040	11002	796	

S 45' LOT 69 H H HALL'S ADD OF 1837				
LAND/LOT ASSESSED	FARM LAND ASSESSED	FARM BLDG. ASSESSED	BUILDING ASSESSED	TOTAL ASSESSED
800			3250	4050
LAND/LOT B.O.R. MULT.	FARM LAND B.O.R. MULT.	FARM BLDG. B.O.R. MULT.	BUILDING B.O.R. MULT.	DEPARTMENT MULTIPLIER
				1.00000
IMPROVEMENT EXEMPTION	DEPARTMENT EQUALIZED	OWNER OCCUPIED	HOMESTEAD/ VETERAN	SCAFHE
	4050			
RETURN VETERAN	DISABLED	DISABLED VETERAN	TAXABLE VALUE	
			4050	

TOWNSHIP	LENDING CODE	LAND/LOT ACRES	FARM LAND ACRES	FORFEITED TAX
VIRGINIA TOWNSHIP	WNH			

WALKER NURSING HOME
 530 E BEARDSTOWN ST
 VIRGINIA IL 62691-0000

PROPERTY OWNER IF OTHER THAN ABOVE

2012 REAL ESTATE TAX

1ST INSTALLMENT		2ND INSTALLMENT
06/28/2013	DUE DATE	09/08/2013
223.97	INSTALLMENT	223.97
	PRE-PAYMENT	
	PENALTY/COST	
	TOTAL	

FAIR CASH VALUE IS 12,150

SEND COUPON WITH PAYMENT OR DUPLICATE TOTAL TAX:
 BILL FEE OF \$2.50 WILL BE CHARGED.
 PENALTY ADDED AFTER DUE DATE PER STATUTE 447.94

PROPERTY NUMBER	CLASS	NUMBER	TOWNSHIP	VIRGINIA TOWNSHIP		
11-052-009-00	0040	796				
2011 RATE	2011 TAX	TAXING DISTRICT	2012 RATE	PERCENT	2012 TAX	PENSION
1.18506	48.00	COUNTY TAX	1.18033	10.7	47.80	18.94
.20457	8.28	AMBULANCE SERVICE	.19965	1.8	8.08	
.20800	8.42	COUNTY HIGHWAY	.20790	1.9	8.42	
.03906	1.58	EXTENSION SERVICE	.03813	.3	1.54	
.08203	3.32	PUBLIC HEALTH DEPT	.08006	.7	3.24	
.07812	3.16	MENTAL HEALTH DEPT	.07625	.7	3.08	
.74701	30.26	VIRGINIA TWP	.74876	6.8	30.32	
6.28140	254.40	UNIT SCHOOL 64	6.14067	55.5	248.70	13.22
.46176	18.70	LINCOLN LAND JC526	.46475	4.2	18.82	.39
1.75774	71.18	VIRGINIA CORP	1.74810	15.8	70.80	9.50
.02760	1.12	MULTI TWP ASSMT #3	.02638	.2	1.06	
15000	6.08	VIRGINIA LIB DIST	.15000	1.4	6.08	
11.22235	454.50	TOTAL TAX	11.06098	100.0	447.94	

BANK CHECK MONEY ORDER DRAFT CASH MAIL

PROPERTY NUMBER	CODE	NUMBER
11-052-009-00	11002	796

BANK CHECK MONEY ORDER DRAFT CASH MAIL

PROPERTY NUMBER	CODE	NUMBER
11-052-009-00	11002	796

RETURN STUB WITH PAYMENT

1

	1ST INSTALLMENT
DUE DATE	06/28/2013
INSTALLMENT	223.97
PRE-PAYMENT	
PENALTY/COST	
TOTAL	



11.00796.2012

RETURN STUB WITH PAYMENT

2

	2ND INSTALLMENT
DUE DATE	09/06/2013
INSTALLMENT	223.97
PRE-PAYMENT	
PENALTY/COST	
TOTAL	



11.00796.2012 Total Tax: 447.94

1.5-5810-04

RETURN STUB WITH PAYMENT

1

	1ST INSTALLMENT
DUE DATE	06/28/2013
INSTALLMENT	11,751.73
PRE-PAYMENT	
PENALTY/COST	
TOTAL	



11.01192.2012

RETURN STUB WITH PAYMENT

2

	2ND INSTALLMENT
DUE DATE	09/06/2013
INSTALLMENT	11,751.73
PRE-PAYMENT	
PENALTY/COST	
TOTAL	



11.01192.2012 Total Tax: 23,503.46

Nov. 8. 2013, 9:40AM Walker Nursing Home
 CASS COUNTY
 MICKI WILSON TREASURER
 PO BOX 167
 VIRGINIA, IL 62691

PROPERTY NUMBER	No. 8367 P. 8 JMBER		
09-033-009-00	0040	09001	556
S 53' OF LOTS 5 & 6 BLK 12 ORIGINAL TOWN			
LAND/LLOT ASSESSED	FARM LAND ASSESSED	FARM BLDG. ASSESSED	BUILDING ASSESSED
400			5045
TOTAL ASSESSED	5445		
LAND/LLOT B.O.R. MULT.	FARM LAND B.O.R. MULT.	FARM BLDG. B.O.R. MULT.	BUILDING B.O.R. MULT.
			DEPARTMENT MULTIPLIER
			1.00000
IMPROVEMENT EXEMPTION	DEPARTMENT EQUALIZED	OWNER OCCUPIED	HOMESTEAD/ VETERAN
	5445		
RETURN VETERAN	DISABLED	DISABLED VETERAN	TAXABLE VALUE
			5445

TOWNSHIP	LENDING CODE	LAND/LLOT ACRES	FARM LAND ACRES	FORFEITED TAX
PHILADELPHIA TWP	WNH			

WALKER NURSING HOME INC
 530 E BEARDSTOWN ST
 VIRGINIA IL 62691-0000

PROPERTY OWNER IF OTHER THAN ABOVE

2012 REAL ESTATE TAX

1ST INSTALLMENT		2ND INSTALLMENT
06/28/2013	DUE DATE	09/06/2013
260.66	INSTALLMENT	260.66
	PRE-PAYMENT	
	PENALTY/COST	
	TOTAL	

FAIR CASH VALUE IS 16,335

SEND COUPON WITH PAYMENT OR DUPLICATE TOTAL TAX: 521.32
 BILL FEE OF \$2.50 WILL BE CHARGED.
 PENALTY ADDED AFTER DUE DATE PER STATUTE

PROPERTY NUMBER	CLASS	NUMBER	TOWNSHIP	PHILADELPHIA TWP
09-033-009-00	0040	556		
2011 RATE	2011 TAX	TAXING DISTRICT	2012 RATE	PERCENT
1.18506	64.52	COUNTY TAX	1.18033	12.3
.20457	11.14	AMBULANCE SERVICE	.19965	2.1
.20800	11.32	COUNTY HIGHWAY	.20790	2.2
.03906	2.12	EXTENSION SERVICE	.03813	.4
.08203	4.46	PUBLIC HEALTH DEPT	.08006	.8
.07812	4.28	MENTAL HEALTH DEPT	.07625	.8
1.18391	64.46	PHILADELPHIA TWP	1.15151	12.0
6.28140	342.02	UNIT SCHOOL #5	6.14067	64.1
.46176	25.14	LINCOLN LAND USE	.46475	4.9
.03454	1.88	MULTI-TWP ASSMT #5	.03476	.4
9.75845	531.32	TOTAL TAX	9.57401	100.0
			2012 TAX	PENSION
			64.26	25.46
			10.88	
			11.32	
			2.08	
			4.36	
			4.16	
			62.70	4.16
			334.36	17.78
			25.30	.52
			1.90	

0 * *

2012 { 260.66 +
 260.66 +
 payable } 1,751.73 +
 2013 { 11,751.73 +

CODE	NUMBER
09001	556

BANK	CHECK	MONEY ORDER	DRAFT	CASH	MAIL
PROPERTY NUMBER			CODE	NUMBER	
09-033-009-00			09001	556	

223.97 +
 223.97 +
 24,472.72 *

24,472.72 x
 9 months → 0.75 =
 18,354.54 *

PAYMENT

ALLMENT
8/2013
260.66



09.00556.2012

RETURN STUB WITH PAYMENT

2

	2ND INSTALLMENT
DUE DATE	09/06/2013
INSTALLMENT	260.66
PRE-PAYMENT	
PENALTY/COST	
TOTAL	



09.00556.2012 Total Tax: 521.32

Facility Name & ID Number Walker Nursing Home

0021428 Report Period Beginning:

10/01/2012 Ending:

09/30/2013

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,040 B. General Construction Type: Exterior Brick Frame Wood and Steel 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).

None

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: N/A 2. Number of Years Over Which it is Being Amortized: N/A
 3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>	<u>22,176</u>	<u>1955</u>	<u>\$ 11,000</u>	1
2	<u>Resident Care</u>	<u>9,504</u>	<u>1981</u>	<u>23,604</u>	2
3	TOTALS	31,680		\$ 34,604	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Home

0021428

Report Period Beginning:

10/01/2012 Ending:

09/30/2013

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	20	1972	1972	\$ 130,523	\$	30	\$	\$	\$ 130,523	4
5	30	1977	1977	363,607		30			363,607	5
6	5	1981	1981	79,226		30			79,226	6
7	16	1985	1985	399,782		30	13,326	13,326	373,124	7
8										8
	Improvement Type**									
9	Leasehold Improvement	1974	900			Various			900	9
10	Leasehold Improvement	1975	200			Various			200	10
11	Leasehold Improvement	1977	2,889			Various			2,889	11
12	Leasehold Improvement	1982	552			Various			552	12
13	Leasehold Improvement	1983	533			Various			533	13
14	Leasehold Improvement	1984	11,510			Various			11,510	14
15	Leasehold Improvement	1985	70,113			Various			70,113	15
16	Leasehold Improvement	1986	7,764			Various	204	204	7,257	16
17	Leasehold Improvement	1988	2,015		64	Various	66	2	1,667	17
18	Leasehold Improvement	1990	2,480			Various			2,480	18
19	Leasehold Improvement	1991	23,204		1,715	Various	781	(934)	17,263	19
20	Leasehold Improvement	1992	45,806		259	Various	1,504	1,245	32,798	20
21	Leasehold Improvement	1993	11,951		364	Various	374	10	7,544	21
22	Leasehold Improvement	1995	4,939		62	Various	62		4,852	22
23	Leasehold Improvement	1996	6,289			Various			6,289	23
24	Leasehold Improvement	1997	63,654		1,986	Various	2,132	146	34,701	24
25	Leasehold Improvement	1998	45,605		1,169	Various	1,144	(25)	17,231	25
26	Leasehold Improvement	1999	2,066		53	Various	53		766	26
27	Leasehold Improvement	2000	4,528			10			4,528	27
28	Shower Faucets	2000	1,550			10			1,550	28
29	Door Locks	2001	1,500			10			1,500	29
30	Water Heater	2002	4,283			10	73	73	4,283	30
31	New Roof	2004	28,437		711	39	729	18	6,790	31
32	Flooring	2005	5,323		133	39	136	3	1,116	32
33	Tiling in Showers	2005	1,062		27	39	27		217	33
34	Sprinkler	2006	860		22	39	22		116	34
35										35
36										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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Home

0021428

Report Period Beginning:

10/01/2012

Ending:

09/30/2013

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	Fire Alarm System	2007	\$ 42,256	\$ 1,057	40	\$ 1,057	\$	\$ 7,007	37
38	Water Line	2007	7,175	179	40	179		1,164	38
39	Concrete Work for Entrance and Walkways	2007	64,272	3,214	20	3,214		14,459	39
40									40
41	Manor Landscaping Improvements	2007	10,560	528	20	528		3,420	41
42	Roof Repairs	2006	3,250	163	20	163		1,079	42
43									43
44	Toilets & Installation	2008	4,354	218	20	218		3,688	44
45	New Railings	2008	6,315	316	20	316		1,738	45
46	Iron Fence	2008	4,895	245	20	245		1,347	46
47	Major Landscaping	2008	11,701	585	20	585		3,222	47
48	Water Heater	2009	5,998	150	40	150		675	48
49	Air Conditioner 10-ton	2009	9,995	250	40	250		1,125	49
50									50
51	Water Heater	2009	5,140	129	40	129		577	51
52	Sprinkler System	2010	45,130	1,541	20	1,541		7,901	52
53	Nurse Call System	2010	48,241	2,412	20	2,412		8,442	53
54	Install Door Alarm System	2011	19,350	484	40	484		1,210	54
55	New Roof on Hall E	2011	31,927	798	40	798		1,995	55
56									56
57	Install New Furnace and AC	2011	5,700	143	40	143		357	57
58	Install Dry Valve w/Trim Sprinkler	2011	4,929	123	40	123		308	58
59									59
60	New Roof Top	2012	7,790	195	40	195		585	60
61	Furnish and Install Blinds and Valances	2010	9,970	499	20	499		499	61
62	Remove/Replace 3 Doors	2011	2,627	66	40	66		66	62
63	6 New Cooling Units for Resident Rooms	2011	4,246	425	10	425		425	63
64	Generator	2012	58,045	484	20	484		484	64
65	Security Cameras	2013	2,726	23	10	23		23	65
66	Tile Flooring - Nurses Station	2013	2,737	6	40	6		6	66
67	New Windows	2013	5,586	35	40	35		35	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,748,066	\$ 20,833		\$ 34,901	\$ 14,068	\$ 1,247,962	70

SEE ACCOUNTANTS' COMPILATION REPORT

**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	\$ 184,136	\$ 21,215	\$ 15,271	\$ (5,944)		\$ 128,437	71
72	Current Year Purchases	69,178	6,944	6,944			6,944	72
73	Fully Depreciated Assets	614,120					614,120	73
74								74
75	TOTALS	\$ 867,434	\$ 28,159	\$ 22,215	\$ (5,944)		\$ 749,501	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	Resident Care	Handicap Bus	2002	\$ 44,983	\$	\$	\$		\$ 44,983	76
77										77
78										78
79										79
80	TOTALS			\$ 44,983	\$	\$	\$		\$ 44,983	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)	\$ 2,695,087	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 48,992	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 57,116	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 8,124	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,042,446	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93		N/A	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.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ N/A			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

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. _____ /2014 \$ _____

13. _____ /2015 \$ _____

14. _____ /2016 \$ _____

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: \$ 3,346 Description: See Attachment Schedule 14A

(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			\$ N/A	\$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/1/2012 Ending: 9/30/2013

Schedule 14A

XII. Rental Costs

Line 16 - Description

Ice Machine	1,260
Dishwasher	828
Copy Machine	1,158
Hardware/Supplies	<u>100</u>
Total Agreeing with P4, L35, C3	<u>3,346</u>

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	L10A, C3	hrs	\$	1,709	\$ 126,196	\$	1,709	\$ 126,196	1	
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		153	11,264		153	11,264	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	L10A, C3	hrs		1,796	132,539		1,796	132,539	4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy	L39, C2	# of prescrpts				8,564		8,564	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify):									12	
13	Other (specify):	L10, C3				7,570			7,570	13	
14	TOTAL			\$	3,658	\$ 277,569	\$ 8,564	3,658	\$ 286,133	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Home# 0021428Report Period Beginning: 10/01/2012Ending: 09/30/2013

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 09/30/2013

(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	\$ 284,098	\$ 284,098	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	486,698	486,698	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	184,869	184,869	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	105,992	105,992	8
9	Other(specify): <u>Employee Advances</u>	300	300	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,061,957	\$ 1,061,957	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	34,604	34,604	13
14	Buildings, at Historical Cost	1,014,765	973,138	14
15	Leasehold Improvements, at Historical Cost	684,636	774,928	15
16	Equipment, at Historical Cost	987,499	912,417	16
17	Accumulated Depreciation (book methods)	(2,043,372)	(2,042,446)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Sec 444 Deposit</u>	14,910	14,910	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 693,042	\$ 667,551	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,754,999	\$ 1,729,508	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 131,912	\$ 131,912	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	54,144	54,144	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	18,354	18,354	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Schedule 17A</u>	7,304	7,304	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 211,714	\$ 211,714	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)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 211,714	\$ 211,714	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,543,285	\$ 1,517,794	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,754,999	\$ 1,729,508	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/1/2012 Ending: 9/30/2013

Schedule 17A

Line 36 - Other Current Liabilities

	Operating	After Consolidation
State Unemployment Payable	3,100	3,100
Federal Unemployment Payable	237	237
State Income Tax Payable	3,967	3,967
	<u>7,304</u>	<u>7,304</u>

SEE ACCOUNTANTS' COMPILATION REPORT

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,415,862	1
2	Restatements (describe):		2
3	Medicare Settlement	11,320	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,427,182	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	327,470	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(211,367)	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)	\$ 116,103	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)	\$ 1,543,285	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Home

0021428

Report Period Beginning: 10/01/2012

Ending: 09/30/2013

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	\$ 2,870,443	1
2	Discounts and Allowances for all Levels	(10,165)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,860,278	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		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,641	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,641	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Void outstanding checks	11,614	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 11,614	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,874,533	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	517,530	31
32	Health Care	1,240,763	32
33	General Administration	506,648	33
B. Capital Expense			
34	Ownership	76,541	34
C. Ancillary Expense			
35	Special Cost Centers	48,000	35
36	Provider Participation Fee	157,581	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,547,063	40
41	Income before Income Taxes (line 30 minus line 40)**	327,470	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 327,470	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 865,516	44
45	Private Pay - Net Inpatient Revenue	782,500	45
46	Medicare - Net Inpatient Revenue	597,299	46
47	Other-(specify) Medicaid Patient Payments	452,574	47
48	Other-(specify) Insurance Receipts	162,389	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,860,278	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Home

0021428

Report Period Beginning: 10/01/2012

Ending: 09/30/2013

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,824	2,916	\$ 81,990	\$ 28.12	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,324	2,369	58,464	24.68	3
4	Licensed Practical Nurses	14,731	15,316	320,264	20.91	4
5	CNAs & Orderlies	31,975	32,829	345,447	10.52	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,987	1,987	21,268	10.70	9
10	Activity Assistants					10
11	Social Service Workers	1,978	2,084	39,944	19.17	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,460	1,500	26,331	17.55	14
15	Cook Helpers/Assistants	9,481	9,701	87,035	8.97	15
16	Dishwashers					16
17	Maintenance Workers	3,268	3,268	46,787	14.32	17
18	Housekeepers	4,770	4,880	45,685	9.36	18
19	Laundry	5,206	5,607	55,682	9.93	19
20	Administrator	1,802	1,802	35,798	19.87	20
21	Assistant Administrator	3,392	3,392	85,924	25.33	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,120	2,120	46,749	22.05	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	87,318	89,771	\$ 1,297,368 *	\$ 14.45	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	88	\$ 4,928	1(3)	35
36	Medical Director	Monthly	8,400	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	Monthly	5,100	11(3)	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	88	\$ 18,428		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		1,330	10(3)	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$ 1,330		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Home

0021428

Report Period Beginning: 10/01/2012

Ending: 09/30/2013

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
George W. White	Co-Administrator	50	\$ 18,952	Workers' Compensation Insurance	\$ 29,750	IDPH License Fee	\$ 3,980		
Mary Ann White	Co-Administrator	50	16,846	Unemployment Compensation Insurance	21,511	Advertising: Employee Recruitment	3,402		
Bryan White	Asst. Administrator	0	42,962	FICA Taxes	98,155	Health Care Worker Background Check			
Rachel White	Asst. Administrator	0	42,962	Employee Health Insurance	24,468	(Indicate # of checks performed)			
				Employee Meals	810	Patient Background Checks	15 150		
				Illinois Municipal Retirement Fund (IMRF)*		Illinois Nursing Home Adm. Assc.	300		
				Employee Medical Services	2,582	Other Subscriptions & Licenses	1,234		
						Public Relations	5,367		
TOTAL (agree to Schedule V, line 17, col. 1)									
(List each licensed administrator separately.)			\$ 121,722						
B. Administrative - Other									
Description			Amount						
			\$						
TOTAL (agree to Schedule V, line 17, col. 3)			\$						
(Attach a copy of any management service agreement)									
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
Cavanagh & O'Hara	Legal Services		\$ 5,997				Out-of-State Travel	\$	
Hurst, Wright & Hafel LLP	Accounting		34,731						
RSM/ M&P	Accounting		2,727				In-State Travel		
Scott & Scott	Legal Services		13,500						
							Seminar Expense	3,346	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 3,346
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 56,955						

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4						N/A						
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Home

0021428

Report Period Beginning: 10/01/2012

Ending: 09/30/2013

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. IL Nursing Home Adm Asse - \$300
- (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? N/A
- (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? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line 10(2)
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 157,581
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? Yes-pg7 If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 810 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (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. \$ N/A
 - c. What percent of all travel expense relates to transportation of nurses and patients? 0
 - d. Have vehicle usage logs been maintained? Adequate records have been maintained
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
 - g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.