

Facility Name & ID Number Walker Nursing Home

0021428 Report Period Beginning: 10/01/2014 Ending: 09/30/2015

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 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		6,291	1,371	7,662	8
9	SNF/PED					9
10	ICF	7,561			7,561	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,561	6,291	1,371	15,223	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 58.74%

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 1,371

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: 09/30/2015 Fiscal Year: 09/30/2015

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	138,023	1,819	5,863	145,705		145,705	145,705			1
2	Food Purchase		120,135		120,135		120,135	120,135			2
3	Housekeeping	55,891	2,236		58,127		58,127	58,127			3
4	Laundry	43,239	90		43,329		43,329	43,329			4
5	Heat and Other Utilities			68,756	68,756		68,756	68,756			5
6	Maintenance	45,388	5,319	22,019	72,726		72,726	72,726			6
7	Other (specify):*										7
8	TOTAL General Services	282,541	129,599	96,638	508,778		508,778	508,778			8
	B. Health Care and Programs										
9	Medical Director			7,700	7,700		7,700	7,700			9
10	Nursing and Medical Records	803,320	47,598	5,875	856,793		856,793	856,793			10
10a	Therapy			223,455	223,455		223,455	223,455			10a
11	Activities	21,099	1,277	5,175	27,551		27,551	27,551			11
12	Social Services	40,922			40,922		40,922	40,922			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Infection Control			6,612	6,612		6,612	6,612			15
16	TOTAL Health Care and Programs	865,341	48,875	248,817	1,163,033		1,163,033	1,163,033			16
	C. General Administration										
17	Administrative	123,785			123,785		123,785	123,785			17
18	Directors Fees										18
19	Professional Services			36,730	36,730		36,730	(943)	35,787		19
20	Dues, Fees, Subscriptions & Promotions			15,292	15,292		15,292	(4,362)	10,930		20
21	Clerical & General Office Expenses	44,868	6,614	27,624	79,106		79,106	79,106			21
22	Employee Benefits & Payroll Taxes			179,597	179,597		179,597	179,597			22
23	Inservice Training & Education										23
24	Travel and Seminar			1,415	1,415		1,415	1,415			24
25	Other Admin. Staff Transportation			11,188	11,188		11,188	11,188			25
26	Insurance-Prop.Liab.Malpractice			37,599	37,599		37,599	37,599			26
27	Other (specify):*										27
28	TOTAL General Administration	168,653	6,614	309,445	484,712		484,712	(5,305)	479,407		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,316,535	185,088	654,900	2,156,523		2,156,523	(5,305)	2,151,218		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.

Facility Name & ID Number **Walker Nursing Home** # **0021428** **Report Period Beginning:** **10/1/2014** **Ending:** **9/30/2015**

<u>Travel & Seminar, Line 24 Col 3</u>	<u>Amount</u>
INAAA (Workshop)	500
Illinois Council on Long Term Care	330 (Workshop 2015 Medicare Updates)
Illinois Department of Public Health	295 (Healthcare & Family Services)
Illinois Food Handlers Assc (CPE)	150
Vicki Fanning (Training)	40
Passavant Area Hospital (CPR Training)	100

1,415

Other Admin Staff Transportation

Line 25, Col 3

Fuel	7,929
Vehicle Repairs	3,094
Bus Rides	165

11,188

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Walker Nursing Home

#0021428

Report Period Beginning:

10/01/2014

Ending:

09/30/2015

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			54,263	54,263	54,263	12,222	66,485				30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			23,708	23,708	23,708		23,708				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			3,637	3,637	3,637		3,637				35
36	Other (specify):*											36
37	TOTAL Ownership			81,608	81,608	81,608	12,222	93,830				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		25,802		25,802	25,802		25,802				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			96,855	96,855	96,855		96,855				42
43	Other (specify):*			29,898	29,898	29,898	(29,898)					43
44	TOTAL Special Cost Centers		25,802	126,753	152,555	152,555	(29,898)	122,657				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,316,535	210,890	863,261	2,390,686	2,390,686	(22,981)	2,367,705				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

STATE OF ILLINOIS

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/1/2014 Ending: 9/30/2015

<u>Other - Line 43, Column 3</u>	<u>Amount</u>
Contributions	464
Advertising	10,086
State Replacement Tax	1,300
Sales Tax	311
Medicare Services	2,375
Labs - Medicare	15,362
	<u>29,898</u>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Home

0021428

Report Period Beginning: 10/01/2014

Ending: 09/30/2015

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				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	12,222	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	(311)	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				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(464)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(943)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(4,362)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,300)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(27,823)	43		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (22,981)		\$	30

BHF USE ONLY					
48		49		50	51
					52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (22,981)		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

SEE ACCOUNTANTS' COMPILATION REPORT

Walker Nursing Home

ID# 0021428

Report Period Beginning: 10/01/2014

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Advertising	\$ (10,086)	43	1
2	Medicare Services	(2,375)	43	2
3	Labs Medicare	(15,362)	43	3
4				4
5				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		(27,823)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Walker Nursing Home

0021428

Report Period Beginning:

10/01/2014

Ending:

09/30/2015

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	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

Facility Name & ID Number Walker Nursing Home

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Report Period Beginning:

10/01/2014 Ending:

Summary B

09/30/2015

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	0	0	0	0	0	0	0	0	0	0	0	0	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	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: 10/01/2014 Ending: 09/30/2015

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mary Ann White	President	Co-Administrator	50.00	0	16	40.00	Salary	\$ 14,370	17(1)	1
2			Office Manager			24	60.00	Salary	21,556	21(1)	2
3											3
4	George W. White	Vice-President	Co-Administrator	50.00	0	18	45.00	Salary	16,167	17(1)	4
5			Maintenance			22	55.00	Salary	19,759	6(1)	5
6											6
7	Bryan White	None	Asst. Admin	0.00	0	32	80.00	Salary	46,624	17(1)	7
8			Clerical			8	20.00	Salary	11,656	21(1)	8
9											9
10	Rachel White	None	Asst. Admin	0.00	0	26	80.00	Salary	46,624	17(1)	10
11			Clerical			6	20.00	Salary	11,656	21(1)	11
12											12
13								TOTAL	\$ 188,412		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:

10/01/2014

Ending:

9/30/2015

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization _____

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									4
5			N/A						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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																	
1. Real Estate Tax accrual used on 2014 report.		\$	17,914	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.)		\$	23,784	2															
3. Under or (over) accrual (line 2 minus line 1).		\$	5,870	3															
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	17,838	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.		\$	23,708	7															
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2010	<u>25,723</u>	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2014 \$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td style="text-align: center;">16</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2014 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
FOR BHF USE ONLY																			
13	FROM R. E. TAX STATEMENT FOR 2014 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
	2011	<u>24,832</u>	9																
	2012	<u>24,472</u>	10																
	2013	<u>23,886</u>	11																
	2014	<u>23,784</u>	12																

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.

SEE ACCOUNTANTS' COMPILATION REPORT

2014 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 2014 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2014.

(A)	(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>506.28</u>	\$ <u>506.28</u>
2. <u>11-052-009-00</u>	<u>Lot</u>	\$ <u>408.12</u>	\$ <u>408.12</u>
3. <u>11-087-007-00</u>	<u>Lot</u>	\$ <u>22,869.90</u>	\$ <u>22,869.90</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. <u>SEE ACCOUNTANTS'</u>	_____	\$ _____	\$ _____
10. <u>COMPILATION REPORT</u>	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>23,784.30</u></u>	\$ <u><u>23,784.30</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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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

Facility Name & ID Number Walker Nursing Home

0021428 Report Period Beginning:

10/01/2014 Ending:

09/30/2015

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:

10/01/2014

Ending:

09/30/2015

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

	1	2	3	4	5	6	7	8	9		
	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	1891	79,226		30			79,226	6
7	16		1985	1985	399,782		30	13,332	13,332	399,782	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	7,665	16
17	Leasehold Improvement		1988		2,015		Various	66	66	1,799	17
18	Leasehold Improvement		1990		2,480		Various			2,480	18
19	Leasehold Improvement		1991		23,204	1,715	Various	781	(934)	18,825	19
20	Leasehold Improvement		1992		45,806	259	Various	1,504	1,245	35,806	20
21	Leasehold Improvement		1993		11,951	364	Various	374	10	8,292	21
22	Leasehold Improvement		1995		4,939	26	Various	25	(1)	4,939	22
23	Leasehold Improvement		1996		6,289		Various			6,289	23
24	Leasehold Improvement		1997		63,654	1,256	Various	2,132	876	38,965	24
25	Leasehold Improvement		1998		45,605	1,169	Various	1,144	(25)	19,519	25
26	Leasehold Improvement		1999		2,066	53	Various	53		872	26
27	Leasehold Improvement		2000		4,528	113	10		(113)	4,528	27
28	Shower Faucets		2000		1,550	39	10		(39)	1,550	28
29	Door Locks		2001		1,500		10			1,500	29
30	Water Heater		2002		4,283		10			4,283	30
31	New Roof		2004		28,437	711	39	729	18	8,248	31
32	Flooring		2005		5,323	133	39	136	3	1,388	32
33	Tiling in Showers		2005		1,062	27	39	27		271	33
34	Sprinkler		2006		860	22	39	22		160	34
35	Fire Alarm System		2007		42,256	1,057	40	1,057		9,121	35
36	Water Line		2007		7,175	179	40	179		1,522	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:

10/01/2014 Ending:

09/30/2015

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Concrete Work for Entrance and Walkways	2007	\$ 64,272	\$ 3,214	20	\$ 3,214		\$ 20,887	37
38	Manor Landscaping Improvements	2007	10,560	528	20	528		4,476	38
39	Roof Repairs	2006	3,250	163	20	163		1,405	39
40	Toilets & Installation	2008	4,354	435	20	218	(217)	4,124	40
41	New Railings	2008	6,315	158	20	316	158	2,370	41
42	Iron Fence	2008	4,895	245	20	245		1,837	42
43	Major Landscaping	2008	11,701	586	20	585	(1)	4,392	43
44	Water Heater	2009	5,998	150	40	150		975	44
45	Air Conditioner 10-ton	2009	9,995	250	40	250		1,625	45
46	Water Heater	2009	5,140	129	40	129		835	46
47	Sprinkler System	2010	45,130	1,218	20	1,541	323	10,983	47
48	Nurse Call System	2010	48,241	4,824	20	2,412	(2,412)	13,266	48
49	Install Door Alarm System	2011	19,350	484	40	484		2,178	49
50	New Roof on Hall E	2011	31,927	798	40	798		3,591	50
51	Install New Furnace and AC	2011	5,700	143	40	143		643	51
52	Install Dry Valve w/Trim Sprinkler	2011	4,929	123	40	123		554	52
53	New Roof Top	2012	7,790	195	40	195		975	53
54	Furnish and Install Blinds and Valances	2010	9,970	499	20	499		1,497	54
55	Remove/Replace 3 Doors	2011	2,627	66	40	66		198	55
56	6 New Cooling Units for Resident Rooms	2011	4,246	425	10	425		1,275	56
57	Generator	2012	58,045	2,902	20	484	(2,418)	1,452	57
58	Security Cameras	2013	2,726	273	10	273		569	58
59	Tile Flooring - Nurses Station	2013	2,737	68	40	68		142	59
60	New Windows	2013	5,586	140	40	140		315	60
61	Generator	2014	5,081	915	20	254	(661)	508	61
62	New Roof on Shed	2014	7,287	182	40	182		212	62
63	New South Furnace & Cooling System	2014	6,318	158	40	158		171	63
64	New Energy Control System	2015	11,338	378	20	47	(331)	47	64
65	New Roof Top A/C Unit	2015	11,640	388	20	49	(339)	49	65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,789,730	\$ 27,160		\$ 35,904	\$ 8,744	\$ 1,319,408	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	\$ 253,314	\$ 22,317	\$ 25,284	\$ 2,967		\$ 185,949	71
72	Current Year Purchases	11,987	1,713	1,713			1,713	72
73	Fully Depreciated Assets	614,120					614,120	73
74								74
75	TOTALS	\$ 879,421	\$ 24,030	\$ 26,997	\$ 2,967		\$ 801,782	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	Resident Care	2008 Chevy Van	2014	12,999	1,592	1,857	265	7	2,321	77
78	Resident Care	Recondition Bus	2014	12,090	1,481	1,727	246	7	1,871	78
79										79
80	TOTALS			\$ 70,072	\$ 3,073	\$ 3,584	\$ 511		\$ 49,175	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)	\$ 2,773,827	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 54,263	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 66,485	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 12,222	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,170,365	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			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

Facility Name & ID Number Walker Nursing Home

0021428

Report Period Beginning: 10/01/2014

Ending: 09/30/2015

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. _____ /2016 \$ _____

13. _____ /2017 \$ _____

14. _____ /2018 \$ _____

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: \$ 3,637 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: 10/1/2014 Ending: 9/30/2015

Schedule 14A

XII. Rental Costs

Line 16 - Description

Ice Machine	1,347
Dishwasher	1,084
Copy Machine	924
Mattress Pumps	<u>282</u>
Total Agreeing with P4, L35, C3	<u>3,637</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? <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 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10A, C3	hrs	\$	1,545	\$ 112,452	\$	1,545	\$ 112,452	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		108	7,850		108	7,850	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		1,411	103,153		1,411	103,153	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				25,802		25,802	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Medical Services</u>	L10, C3				5,875			5,875	12
13	Other (specify):									13
14	TOTAL			\$	3,064	\$ 229,330	\$ 25,802	3,064	\$ 255,132	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: 10/01/2014Ending: 09/30/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 09/30/2015 (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 156,051	\$ 156,051	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	526,318	526,318	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	189,032	189,032	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>	4,908	4,908	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 982,301	\$ 982,301	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	1,022,052	973,138	14
15	Leasehold Improvements, at Historical Cost	713,931	816,592	15
16	Equipment, at Historical Cost	1,029,656	949,493	16
17	Accumulated Depreciation (book methods)	(2,156,463)	(2,170,365)	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>Section 4444 Deposit</u>	4,558	4,558	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 648,338	\$ 608,020	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,630,639	\$ 1,590,321	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 93,105	\$ 93,105	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	11,059	11,059	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	17,838	17,838	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	1,300	1,300	35
	Other Current Liabilities(specify):			
36	<u>Accrued Payroll Taxes</u>	2,518	2,518	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 125,820	\$ 125,820	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)	\$ 125,820	\$ 125,820	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,504,819	\$ 1,464,501	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,630,639	\$ 1,590,321	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/1/2014 Ending: 9/30/2015

Schedule 17A

Line 36 - Other Current Liabilities

	Operating	After Consolidation
State Unemployment Payable	2,218	2,218
Federal Unemployment Payable	228	228
State Withholding Withheld	72	72
	<u>2,518</u>	<u>2,518</u>

SEE ACCOUNTANTS' COMPILATION REPORT

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,439,273	1
2	Restatements (describe):		2
3	State Replacement Tax	(497)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,438,776	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	84,840	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	(18,797)	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)	\$ 66,043	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)	\$ 1,504,819	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 2,479,679	1
2	Discounts and Allowances for all Levels	(7,201)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,472,478	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***	2,635	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,635	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Refunds</u>	413	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 413	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,475,526	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	508,778	31
32	Health Care	1,163,033	32
33	General Administration	484,712	33
B. Capital Expense			
34	Ownership	81,608	34
C. Ancillary Expense			
35	Special Cost Centers	55,700	35
36	Provider Participation Fee	96,855	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,390,686	40
41	Income before Income Taxes (line 30 minus line 40)**	84,840	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 84,840	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 535,578	44
45	Private Pay - Net Inpatient Revenue	1,452,199	45
46	Medicare - Net Inpatient Revenue	417,225	46
47	Other-(specify) <u>Insurance</u>	67,476	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,472,478	49

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Home

0021428

Report Period Beginning: 10/01/2014

Ending: 09/30/2015

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,829	1,845	\$ 57,367	\$ 31.09	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,756	3,898	103,905	26.66	3
4	Licensed Practical Nurses	14,754	15,382	329,421	21.42	4
5	CNAs & Orderlies	28,680	29,438	312,627	10.62	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,169	2,170	21,099	9.72	9
10	Activity Assistants					10
11	Social Service Workers	1,983	2,089	40,922	19.59	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,023	2,159	40,523	18.77	14
15	Cook Helpers/Assistants	9,752	10,167	97,500	9.59	15
16	Dishwashers					16
17	Maintenance Workers	3,245	3,301	45,388	13.75	17
18	Housekeepers	5,360	5,540	55,891	10.09	18
19	Laundry	3,900	4,096	43,239	10.56	19
20	Administrator	1,802	1,802	30,537	16.95	20
21	Assistant Administrator	3,392	3,392	93,248	27.49	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,120	2,120	44,868	21.16	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)	84,765	87,399	\$ 1,316,535 *	\$ 15.06	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	97	\$ 5,863	1(3)	35
36	Medical Director	Monthly	7,700	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	5,175	11(3)	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	97	\$ 18,738		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 16,167	Workers' Compensation Insurance	\$ 53,010	IDPH License Fee	\$ 3,980		
Mary Ann White	Co-Administrator	50	14,370	Unemployment Compensation Insurance	14,551	Advertising: Employee Recruitment	5,331		
Bryan White	Asst. Administrator	0	46,624	FICA Taxes	103,916	Health Care Worker Background Check			
Rachel White	Asst. Administrator	0	46,624	Employee Health Insurance	7,239	(Indicate # of checks performed <u>7</u>)	203		
				Employee Meals	303	Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Public Relations	4,362		
				Employee Medical Services	578	Other Subscriptions & Licenses	1,416		
TOTAL (agree to Schedule V, line 17, col. 1)									
(List each licensed administrator separately.)			\$ 123,785						
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
			\$			\$	Out-of-State Travel	\$	
							In-State Travel		
							Seminar Expense	1,415	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL			\$	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 10,930
(Attach a copy of any management service agreement)				(agree to Schedule V, line 22, col.8)				(agree to Sch. V, line 24, col. 8)	
C. Professional Services				G. Schedule of Travel and Seminar**					
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
Cavanagh & O'Hara	Legal Services		\$ 943			\$	Out-of-State Travel	\$	
Hurst, Wright & Hafel LLP	Accounting		35,519				In-State Travel		
National Corp	Delaware Rep		168				Seminar Expense	1,415	
R.W. Troxell	Workmen's Comp Service		100				Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3)			\$	TOTAL			\$	TOTAL	\$ 1,415
(For legal fee disclosure, see page 39 of instructions)			\$ 36,730					(agree to Sch. V, line 24, col. 8)	

* 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: 10/01/2014

Ending: 09/30/2015

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IL Nursing Home Adm Assc - \$200
- (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? 7 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. \$ 96,855
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-Pg 7 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. \$ 303 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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees.