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## INDEPENDENT ACCOUNTANTS' PREPARATION REPORT

Board of Directors  
Walker Nursing Home, Inc.  
Virginia, Illinois

We have prepared the accompanying Financial and Statistical Report for Long-Term Care Facilities for Walker Nursing Home, Inc. for the year ended September 30, 2017 in the form prescribed by the State of Illinois Department of Healthcare and Family Services. We have not audited, reviewed or compiled the accompanying report and, accordingly, do not express an opinion or any other form of assurance about whether the report is in accordance with accounting principles generally accepted in the United States of America or in accordance with the requirements of the State of Illinois Department of Healthcare and Family Services, which differ from accounting principles generally accepted in the United States of America. Accordingly, the Financial and Statistical Report for Long-Term Care Facilities is not designed for those who are not informed about such differences.

Management is responsible for the preparation and fair presentation of the accompanying Financial and Statistical Report for Long-Term Care Facilities in accordance with the requirements of the State of Illinois Department of Healthcare and Family Services, and for designing, implementing, and maintaining internal control relevant to the preparation and fair presentation of the Financial and Statistical Report for Long-Term Care Facilities.

Our responsibility is to prepare the report in accordance with the requirements of the State of Illinois Department of Healthcare and Family Services. The objective of the preparation of the Financial and Statistical Report for Long-Term Care Facilities is to assist management in presenting financial information in the form prescribed by the State of Illinois Department of Healthcare and Family Services without undertaking to obtain or provide any assurance that there are no material modifications that should be made to the Financial and Statistical Report for Long-Term Care Facilities.

*Kerber, Eck + Braeckel LLP*

Springfield, Illinois  
December 20, 2017

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Other Locations

Belleville, IL • Carbondale, IL • Columbia, IL • Harrisburg, IL • Litchfield, IL • Cape Girardeau, MO • St. Louis, MO • Milwaukee, WI



Facility Name & ID Number WALKER NURSING HOME

# 0021428 Report Period Beginning: 10/01/2016 Ending: 09/30/2017

**III. STATISTICAL DATA**

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF		6,620	1,354	7,974	8
9	SNF/PED					9
10	ICF	7,380			7,380	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,380	6,620	1,354	15,354	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.25%**

**D. How many bed reserve days during this year were paid by the Department?**  
NONE (Do not include bed reserve days in Section B.)

**E. List all services provided by your facility for non-patients.**  
(E.g., day care, "meals on wheels", outpatient therapy)  
NONE

**F. Does the facility maintain a daily midnight census?** YES

**G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?**  
YES  NO

**H. Does the BALANCE SHEET (page 17) reflect any non-care assets?**  
YES  NO

**I. On what date did you start providing long term care at this location?**  
Date started 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 1,354

Medicare Intermediary Wisconsin Physician Services

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 09/30/2017 Fiscal Year: 09/30/2017

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number **WALKER NURSING HOME** # **0021428** Report Period Beginning: **10/01/2016** Ending: **09/30/2017**

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	146,737	312	4,516	151,565		151,565		151,565		1
2	Food Purchase		128,878		128,878		128,878		128,878		2
3	Housekeeping	70,416	2,323		72,739		72,739		72,739		3
4	Laundry	51,580	115		51,695		51,695		51,695		4
5	Heat and Other Utilities			63,674	63,674		63,674		63,674		5
6	Maintenance	41,446	11,477	23,593	76,516		76,516		76,516		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	310,179	143,105	91,783	545,067		545,067		545,067		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			8,400	8,400		8,400		8,400		9
10	Nursing and Medical Records	971,766	54,273	8,477	1,034,516		1,034,516		1,034,516		10
10a	Therapy			229,936	229,936		229,936		229,936		10a
11	Activities	40,331	3,346	5,300	48,977		48,977		48,977		11
12	Social Services	43,946			43,946		43,946		43,946		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <b>INFECTION CONTROL</b>			6,019	6,019		6,019		6,019		15
16	<b>TOTAL Health Care and Programs</b>	1,056,043	57,619	258,132	1,371,794		1,371,794		1,371,794		16
	<b>C. General Administration</b>										
17	Administrative	132,572			132,572		132,572		132,572		17
18	Directors Fees										18
19	Professional Services			30,508	30,508		30,508	(1,300)	29,208		19
20	Dues, Fees, Subscriptions & Promotions			17,515	17,515		17,515	(7,252)	10,263		20
21	Clerical & General Office Expenses	43,580	9,690	27,366	80,636		80,636		80,636		21
22	Employee Benefits & Payroll Taxes			205,154	205,154		205,154		205,154		22
23	Inservice Training & Education			5,137	5,137		5,137		5,137		23
24	Travel and Seminar			1,005	1,005		1,005		1,005		24
25	Other Admin. Staff Transportation			16,475	16,475		16,475		16,475		25
26	Insurance-Prop.Liab.Malpractice			36,537	36,537		36,537		36,537		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	176,152	9,690	339,697	525,539		525,539	(8,552)	516,987		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,542,374	210,414	689,612	2,442,400		2,442,400	(8,552)	2,433,848		29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

<u>Inservice Training &amp; Education - Line 23 (3)</u>	<u>Amount</u>	<u>Other Admin. Staff Travel &amp; Transportation - Line 25 (3)</u>	<u>Amount</u>
American Ambulance - CPR Classes	580	Fuel	10,009
Azer Seminars - Rehab training	249	Vehicle Repairs	6,466
Reliance Learning - Monthly Staff Training videos	4,308		
	<u>5,137</u>		<u>16,475</u>
	<u>5,137</u>		<u>16,475</u>
 <u>Travel and Seminar - Line 24 (3)</u>	 <u>Amount</u>		
IL NHAA Meetings	380		
MDS Advanced Training	625		
	<u>1,005</u>		
	<u>1,005</u>		

**SEE ACCOUNTANTS' PREPARATION REPORT**

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	
	<b>D. Ownership</b>											
30	Depreciation			55,834	55,834		55,834	1,242	57,076			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			24,473	24,473		24,473		24,473			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			3,990	3,990		3,990		3,990			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			84,297	84,297		84,297	1,242	85,539			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		38,385		38,385		38,385		38,385			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			123,950	123,950		123,950		123,950			42
43	Other (specify):*			37,814	37,814		37,814	(37,814)				43
44	<b>TOTAL Special Cost Centers</b>		38,385	161,764	200,149		200,149	(37,814)	162,335			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	1,542,374	248,799	935,673	2,726,846		2,726,846	(45,124)	2,681,722			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

<u>Other - Line 43, Column 3</u>	Amount
Sales Tax	390
Contributions	980
State Replacement Tax	494
Advertising	19,548
Medicare Services	4,557
Labs - Medicare	11,765
Clothing & Supplies - Residents	80
	<u>37,814</u>

**SEE ACCOUNTANTS' PREPARATION REPORT**

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	1,242	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	(390)	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	(980)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,300)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(7,252)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(494)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(35,950)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (45,124)		\$	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	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (45,124)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' PREPARATION REPORT

## WALKER NURSING HOME

ID# 0021428

Report Period Beginning: 10/01/2016

Ending: 09/30/2017

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Advertising	\$ (19,548)	43	1
2	Medicare Services	(4,557)	43	2
3	Labs - Medicare	(11,765)	43	3
4	Clothing & Supplies - Residents	(80)	43	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
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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	<b>Total</b>	(35,950)		49

**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	<b>Total</b>		\$			\$	\$ *	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name &amp; ID Number

WALKER NURSING HOME

# 0021428

Report Period Beginning:

10/01/2016

Ending:

09/30/2017

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mary Ann White	President	Co-Administrator	50.00	0	16	40.00	Salary	\$ 10,516	17(I)	1
2			Office Manager			24	60.00	Salary	15,774	21(I)	2
3											3
4	George W White	Vice-President	Co-Administrator	50.00	0	18	45.00	Salary	10,831	17(I)	4
5			Maintenance			22	55.00	Salary	13,237	6(I)	5
6											6
7	Bryan White	none	Asst. Admin	0.00	0	32	80.00	Salary	57,797	17(I)	7
8			Clerical			8	20.00	Salary	13,903	21(I)	8
9											9
10	Rachel White	none	Asst. Admin	0.00	0	32	80.00	Salary	53,428	17(I)	10
11			Clerical			8	20.00	Salary	13,903	21(I)	11
12											12
13								TOTAL	\$ 189,389		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' PREPARATION REPORT

Facility Name & ID Number WALKER NURSING HOME

# 0021428

Report Period Beginning:

10/01/2016

Ending: 9/30/2017

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2	N/A		N/A						2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

WALKER NURSING HOME

# 0021428

Report Period Beginning:

10/01/2016

Ending:

09/30/2017

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
	<b>A. Directly Facility Related</b>																	
	<b>Long-Term</b>																	
1							\$	\$				\$						
2																		
3																		
4																		
5																		
	<b>Working Capital</b>																	
6																		
7																		
8																		
9	<b>TOTAL Facility Related</b>						\$	\$				\$						
	<b>B. Non-Facility Related*</b>																	
10																		
11																		
12																		
13																		
14	<b>TOTAL Non-Facility Related</b>						\$	\$				\$						
15	<b>TOTALS (line 9+line14)</b>						\$	\$				\$						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$   N/A                        Line #   N/A  

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

SEE ACCOUNTANTS' PREPARATION REPORT

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

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

**B. Real Estate Taxes**

**Important, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.**

1. Real Estate Tax accrual used on 2016 report.		\$	<b>17,978</b>	<b>1</b>
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.)		\$	<b>24,258</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>6,280</b>	<b>3</b>
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>18,193</b>	<b>4</b>
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		<b>5</b>
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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>24,473</b>	<b>7</b>

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	<b>2012</b>	<b>24,472</b>	<b>8</b>
	<b>2013</b>	<b>23,886</b>	<b>9</b>
	<b>2014</b>	<b>23,784</b>	<b>10</b>
	<b>2015</b>	<b>23,970</b>	<b>11</b>
	<b>2016</b>	<b>24,258</b>	<b>12</b>

**FOR BHF USE ONLY**

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

**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' PREPARATION REPORT

**2016 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 217-789-0960 FAX #: 217-789-2822

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2016 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2016.

(A)	(B)	(C)	(D) <u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1. <u>09-033-009-00</u>	<u>Lot</u>	\$ <u>517.54</u>	\$ <u>517.54</u>
2. <u>11-052-009-00</u>	<u>Lot</u>	\$ <u>416.20</u>	\$ <u>416.20</u>
3. <u>11-087-007-00</u>	<u>Lot</u>	\$ <u>23,323.78</u>	\$ <u>23,323.78</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>24,257.52</u></u>	\$ <u><u>24,257.52</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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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

CASS COUNTY  
 TRAVIS COX TREASURER  
 PO BOX 167  
 VIRGINIA, IL 62691

PROPERTY NUMBER	CLASS	CODE	NUMBER	
09-033-009-00	0040	09001	566	
S 53' OF LOTS 5 & 6 BLK 12 ORIGINAL TOWN (53' X 100')				
LANDLOT ASSESSED	FARM LAND ASSESSED	FARM BLDG. ASSESSED	BUILDING ASSESSED	TOTAL ASSESSED
410			5190	5600
LANDLOT 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
	5600			
RETURN VETERAN	DISABLED	DISABLED VETERAN	TAXABLE VALUE	
			5600	

TOWNSHIP	LENDING CODE	LANDLOT 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

**2016 REAL ESTATE TAX**

1ST INSTALLMENT		2ND INSTALLMENT
06/30/2017	DUE DATE	09/01/2017
258.77	INSTALLMENT	258.77
	PRE-PAYMENT	
	PENALTY/COST	
	<b>TOTAL</b>	

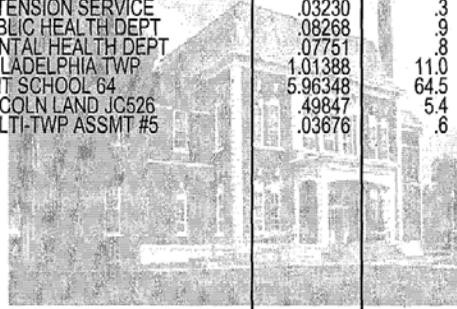
FAIR CASH VALUE IS 16,800

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

**TOTAL TAX:**

**517.54**

PROPERTY NUMBER	CLASS	NUMBER	TOWNSHIP	PHILADELPHIA TWP
09-033-009-00	0040	566		
2015 RATE	2015 TAX	TAXING DISTRICT	2016 RATE	PERCENT
1.17039	64.38	COUNTY TAX	1.15921	12.5
.17800	9.80	AMBULANCE SERVICE	.16915	1.8
.20770	11.42	COUNTY HIGHWAY	.20800	2.2
.03399	1.86	EXTENSION SERVICE	.03230	.3
.08701	4.78	PUBLIC HEALTH DEPT	.08268	.9
.07138	3.92	MENTAL HEALTH DEPT	.07751	.8
1.01817	56.00	PHILADELPHIA TWP	1.01388	11.0
6.04872	332.68	UNIT SCHOOL 64	5.96348	64.5
.50109	27.56	LINCOLN LAND JC526	.49847	5.4
.03636	2.00	MULTI-TWP ASSMT #5	.03676	.6
9.35281	514.40	<b>TOTAL TAX</b>	9.24144	100.0
				2016 TAX
				517.54
				PENSION
				21.79



*PD 08-31-17  
 ac #45403  
 2nd*

CASS COUNTY  
 TRAVIS COX TREASURER  
 PO BOX 167  
 VIRGINIA, IL 62691

PROPERTY NUMBER	CLASS	CODE	NUMBER
11-052-009-00	0040	11002	803
S 45' LOT 69 H H HALL'S ADD OF 1837 (45' X 60')			
LAND/LOT ASSESSED	FARM LAND ASSESSED	FARM BLDG. ASSESSED	BUILDING ASSESSED
555			3345
			TOTAL ASSESSED
			3900
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
	3900		SCAFHE
RETURN VETERAN	DISABLED	DIGABLED VETERAN	TAXABLE VALUE
			3900

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

**2016 REAL ESTATE TAX**

1ST INSTALLMENT		2ND INSTALLMENT
06/30/2017	DUE DATE	09/01/2017
208.10	INSTALLMENT	208.10
	PRE-PAYMENT	
	PENALTY/COST	
<b>TOTAL</b>		

FAIR CASH VALUE IS 11,700

SEND COUPON WITH PAYMENT OR DUPLICATE BILL FEE OF \$2.50 WILL BE CHARGED.  
 PENALTY ADDED AFTER DUE DATE PER STATUTE **416.20**

PROPERTY NUMBER	CLASS	NUMBER	TOWNSHIP	VIRGINIA TOWNSHIP
11-052-009-00	0040	803		
2015 RATE	2015 TAX	TAXING DISTRICT	2016 RATE	PERCENT
1.17039	44.82	COUNTY TAX	1.15921	10.9
.17800	6.82	AMBULANCE SERVICE	.16915	1.6
.20770	7.96	COUNTY HIGHWAY	.20800	2.0
.03399	1.30	EXTENSION SERVICE	.03230	.3
.08701	3.34	PUBLIC HEALTH DEPT	.08268	.8
.07138	2.74	MENTAL HEALTH DEPT	.07751	.7
.71955	27.56	VIRGINIA TWP	.71768	6.7
6.04872	231.66	UNIT SCHOOL 64	5.96348	55.9
.50109	19.20	LINCOLN LAND JC526	.49847	4.7
1.55958	59.74	VIRGINIA CORP	1.60734	15.1
.01799	.68	MULTI-TWP ASSMT #3	.01726	.2
.14223	5.44	VIRGINIA LIB DIST	.13921	1.1
10.73763	411.26	<b>TOTAL TAX</b>	10.67229	100.0
			45.20	
			6.60	
			8.12	
			1.26	
			3.22	
			3.02	
			27.98	
			232.58	4.22
			19.44	.32
			62.68	8.18
			.68	
			5.42	
			416.20	

PAID 08-31-17  
 CE # 45402  
 RMD

CASS COUNTY  
 TRAVIS COX TREASURER  
 PO BOX 167  
 VIRGINIA, IL 62691

TOWNSHIP	LENDING CODE	LANDLOT ACRES	FARM LAND ACRES	FORFEITED TAX
VIRGINIA TOWNSHIP	WNH			

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

PROPERTY NUMBER	CLASS	CODE	NUMBER
11-087-007-00	0060	11002	1194

LOT 3 EXC 4 2/5' OFF E SD ALSO 31.3' X 45'  
 NW COR OF LOT 7 & LOTS 4, 5 & 6 & 45' N SD.  
 LOT 9 BLK 3  
 BEER'S CHESTON HILL ADD

LANDLOT ASSESSED	FARM LAND ASSESSED	FARM BLDG. ASSESSED	BUILDING ASSESSED	TOTAL ASSESSED
10275			208270	218545

LANDLOT 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
	218545			

RETURN VETERAN	DISABLED	DISABLED VETERAN	TAXABLE VALUE
			218545

PROPERTY OWNER IF OTHER THAN ABOVE

**2016 REAL ESTATE TAX**

1ST INSTALLMENT	DUE DATE	2ND INSTALLMENT
06/30/2017		09/01/2017
11,661.89	INSTALLMENT	11,661.89
	PRE-PAYMENT	
	PENALTY/COST	
	<b>TOTAL</b>	

SEND COUPON WITH PAYMENT OR DUPLICATE BILL FEE OF \$2.50 WILL BE CHARGED.  
 PENALTY ADDED AFTER DUE DATE PER STATUTE **TOTAL TAX: 23,323.78**

PROPERTY NUMBER	CLASS	NUMBER	TOWNSHIP	VIRGINIA TOWNSHIP		
11-087-007-00	0060	1194	TOWNSHIP	VIRGINIA TOWNSHIP		
2015 RATE	2015 TAX	TAXING DISTRICT	2016 RATE	PERCENT	2016 TAX	PENSION
1.17039	2,511.84	COUNTY TAX	1.15921	10.9	2,533.40	850.18
.17800	382.02	AMBULANCE SERVICE	.16915	1.6	369.66	
.20770	445.76	COUNTY HIGHWAY	.20800	1.9	454.58	
.03399	72.94	EXTENSION SERVICE	.03230	.3	70.60	
.08701	186.74	PUBLIC HEALTH DEPT	.08268	.8	180.70	
.07138	153.20	MENTAL HEALTH DEPT	.07751	.7	169.40	
.71955	1,544.26	VIRGINIA TWP	.71788	6.7	1,568.46	
6.04872	12,981.46	UNIT SCHOOL 84	5.96348	55.9	13,032.88	236.24
.50109	1,075.42	LINCOLN LAND JC526	.49847	4.7	1,089.38	17.77
1.55958	3,347.10	VIRGINIA CORP	1.60734	15.1	3,512.76	458.18
.01799	38.60	MULTI-TWP ASSMT #3	.01726	.2	37.72	
.14223	305.24	VIRGINIA LIB DIST	.13921	1.2	304.24	
10.73763	23,044.58	<b>TOTAL TAX</b>	10.67229	100.0	23,323.78	

*PD 08-31-17  
 Ck # 45404  
 2 20*

Facility Name & ID Number WALKER NURSING HOME

# 0021428

Report Period Beginning:

10/01/2016 Ending:

09/30/2017

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,040 B. General Construction Type: Exterior Brick Frame Wood & Steel Number of Stories 1

C. Does the Operating Entity? [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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 [X] 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:

A. Land.

Table with 6 columns: Item, Use, Square Feet, Year Acquired, Cost, and Item Number. Rows include Resident Care (22,176 sq ft, 1955, \$11,000) and Resident Care (9,504 sq ft, 1981, \$23,604), plus a TOTALS row (31,680 sq ft, \$34,604).

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name &amp; ID Number WALKER NURSING HOME

# 0021428

Report Period Beginning:

10/01/2016 Ending:

09/30/2017

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	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			399,782	7
8											8
	<b>Improvement Type**</b>										
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			7,764	16
17	Leasehold Improvement		1988		2,015		Various	67	67	1,933	17
18	Leasehold Improvement		1990		2,480		Various			2,480	18
19	Leasehold Improvement		1991		23,204	519	Various	773	254	20,371	19
20	Leasehold Improvement		1992		45,806	1,455	Various	1,527	72	38,860	20
21	Leasehold Improvement		1993		11,951	364	Various	306	(58)	8,904	21
22	Leasehold Improvement		1995		4,939		Various			4,939	22
23	Leasehold Improvement		1996		6,289		Various			6,289	23
24	Leasehold Improvement		1997		63,654	1,256	Various	1,258	2	41,481	24
25	Leasehold Improvement		1998		45,605	1,169	Various	1,169		21,857	25
26	Leasehold Improvement		1999		2,066	53	Various	53		978	26
27	Leasehold Improvement		2000		6,078		10			6,078	27
28	Door Locks		2001		1,500		10			1,500	28
29	Water Heater		2002		4,283		10			4,283	29
30	New Roof		2004		28,437	711	39	729	18	9,706	30
31	Flooring		2005		5,323	133	39	136	3	1,660	31
32	Tiling in Showers		2005		1,062	27	39	27		325	32
33	Sprinkler		2006		860	22	39	22		204	33
34	Roof Repairs		2006		3,250	165	20	163	(2)	1,731	34
35	Fire Alarm System		2007		42,256	1,047	40	1,056	9	11,233	35
36	Water Line		2007		7,175	179	40	179		1,880	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' PREPARATION REPORT

Facility Name &amp; ID Number WALKER NURSING HOME

# 0021428

Report Period Beginning:

10/01/2016 Ending: 09/30/2017

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Concrete Work for Entrance and Walkways	2007	\$ 64,272	\$ 3,214	20	\$ 3,214		\$ 27,315	37
38	Manor Landscaping Improvements	2007	10,560	528	20	528		5,532	38
39	Toilets & Installation	2008	4,354	12	20	12		4,354	39
40	New Railings	2008	6,315	158	20	162	4	2,694	40
41	Iron Fence	2008	4,895	245	20	245		2,327	41
42	Major Landscaping	2008	11,701	586	20	585	(1)	5,562	42
43	Water Heater	2009	5,998	150	40	150		1,275	43
44	Air Conditioner - 10 ton	2009	9,995	250	40	250		2,125	44
45	Water Heater	2009	5,140	129	40	129		1,093	45
46	Sprinkler Systems	2010	45,130	1,218	20	2,257	1,039	15,497	46
47	Nurse Call System	2010	48,241	2,412	20	2,412		18,090	47
48	Furnish & Install Blinds & Valances	2010	9,970	499	20	499		2,495	48
49	Install Door Alarm System	2011	19,350	484	40	484		3,146	49
50	New Roof on Hall E	2011	31,927	798	40	798		5,187	50
51	Install New Furnace & Air Conditioner	2011	5,700	143	40	143		929	51
52	Install Dry Valve w/ Trim Sprinkler	2011	4,929	123	40	123		800	52
53	Remove/replace 3 doors	2011	2,627	66	40	66		330	53
54	6 New Cooling Units for Resident Rooms	2011	4,246	425	10	425		2,125	54
55	Generator	2012	58,045	2,902	20	2,902		7,256	55
56	New Roof Top	2012	7,790	195	40	195		1,365	56
57	Security Cameras	2013	2,726	273	10	273		1,115	57
58	Tile Flooring - Nurses Station	2013	2,737	68	40	68		278	58
59	New Windows	2013	5,586	140	40	140		595	59
60	Generator	2014	5,081	585	20	254	(331)	1,016	60
61	New Roof on Shed	2014	7,287	182	40	182		576	61
62	New South Furnace & Cooling System	2014	6,318	158	40	158		487	62
63	New Energy Control System	2015	11,338	756	20	567	(189)	1,181	63
64	New Roof Top A/C Unit	2015	11,640	776	20	582	(194)	1,213	64
65	New Brick Wall & Concrete Work	2016	3,425	171	20	171		328	65
66	New Roof A/C	2016	3,634	242	20	182	(60)	227	66
67	New Tile & Installation - North Hall	2017	5,627	129	40	129		129	67
68	New Water Heater & Installation	2017	8,656	721	10	721		721	68
69	North Hall - New Water Heater & Install	2017	8,615	359	10	359		359	69
70	TOTAL (lines 4 thru 69)		\$ 1,819,687	\$ 26,197		\$ 26,830	\$ 633	\$ 1,372,013	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number **WALKER NURSING HOME**

# **0021428**

Report Period Beginning:

**10/01/2016**

Ending:

**09/30/2017**

**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	\$ 172,524	\$ 25,047	\$ 26,605	\$ 1,558	various	\$ 128,603	71
72	Current Year Purchases	5,792	828	355	(473)	various	355	72
73	Fully Depreciated Assets	725,680				various	725,680	73
74								74
75	<b>TOTALS</b>	\$ 903,996	\$ 25,875	\$ 26,960	\$ 1,085		\$ 854,638	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	1,949	1,703	(246)	7	5,881	77
78	Resident Care	Recondition Bus	2014	12,090	1,813	1,583	(230)	7	5,181	78
79										79
80	<b>TOTALS</b>			\$ 70,072	\$ 3,762	\$ 3,286	\$ (476)		\$ 56,045	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)	\$ 2,828,359	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 55,834	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 57,076	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,242	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,282,696	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	<b>TOTALS</b>	\$	\$	\$	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' PREPARATION 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:				\$			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$			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.	_____ /2018	\$ _____
13.	_____ /2019	\$ _____
14.	_____ /2020	\$ _____

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: \$ **3,990** 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			\$	\$	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	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' PREPARATION REPORT

Schedule 14A

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XII. Rental Costs

Line 16 - Description

Ice Machine	1,440
Dishwasher	690
Copy Machine	885
Pressure Pumps	323
Small Tools	652
	<hr/>
	3,990
	<hr/> <hr/>

**SEE ACCOUNTANTS' PREPARATION REPORT**

**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input 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. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			
		1	2	3	4
		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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' PREPARATION REPORT**

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10A C3	hrs	\$	1,673	\$ 120,446	\$	1,673	\$ 120,446	1
2	Licensed Speech and Language Development Therapist	L10A C3	hrs		122	6,165		122	6,165	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A C3	hrs		1,435	103,325		1,435	103,325	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				38,385		38,385	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				324			324	12
13	Other (specify): _____									13
14	<b>TOTAL</b>			\$	3,230	\$ 230,260	\$ 38,385	3,230	\$ 268,645	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' PREPARATION REPORT

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **09/30/2017**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 41,659	\$ 41,659	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	529,971	529,971	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments	192,949	192,949	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): <b>Employee Advances</b>	9,300	9,300	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 879,871	\$ 879,871	10
	<b>B. Long-Term Assets</b>			
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	743,888	846,550	15
16	Equipment, at Historical Cost	1,054,230	974,068	16
17	Accumulated Depreciation (book methods)	(2,268,858)	(2,282,696)	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 (spe <b>Deposit - Sec 444</b> )	11,923	11,923	22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 597,839	\$ 557,587	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,477,710	\$ 1,437,458	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 88,677	\$ 88,677	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	29,236	29,236	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	18,193	18,193	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<b>State Withholding Payable</b>	(1,796)	(1,796)	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 134,310	\$ 134,310	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 134,310	\$ 134,310	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,343,400	\$ 1,303,148	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,477,710	\$ 1,437,458	48

SEE ACCOUNTANTS' PREPARATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,570,590</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>1,570,590</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(171,770)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	(55,420)	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (227,190)	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,343,400</b>	<b>24</b> *

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION 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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,566,165	1
2	Discounts and Allowances for all Levels	(15,938)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,550,227	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	2,012	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 2,012	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Refunds</u>	2,837	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 2,837	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,555,076	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	545,067	31
32	Health Care	1,371,794	32
33	General Administration	525,539	33
<b>B. Capital Expense</b>			
34	Ownership	84,297	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	200,149	35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,726,846	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(171,770)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (171,770)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 549,264	44
45	Private Pay - Net Inpatient Revenue	1,283,997	45
46	Medicare - Net Inpatient Revenue	543,123	46
47	Other-(specify) <u>Insurance Revenue</u>	173,843	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 2,550,227	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' PREPARATION REPORT

Facility Name & ID Number **WALKER NURSING HOME**

# 0021428

Report Period Beginning: 10/01/2016

Ending: 09/30/2017

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,213	1,251	\$ 50,588	\$ 40.44	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,399	5,519	175,368	31.78	3
4	Licensed Practical Nurses	13,459	13,700	350,466	25.58	4
5	CNAs & Orderlies	29,745	30,342	395,344	13.03	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,598	3,671	40,331	10.99	9
10	Activity Assistants					10
11	Social Service Workers	2,025	2,064	43,946	21.29	11
12	Dietician					12
13	Food Service Supervisor	1,986	2,022	42,774	21.15	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,739	9,928	103,963	10.47	15
16	Dishwashers					16
17	Maintenance Workers	3,257	3,319	41,446	12.49	17
18	Housekeepers	6,199	6,320	70,416	11.14	18
19	Laundry	4,144	4,229	51,580	12.20	19
20	Administrator	1,654	1,688	21,347	12.65	20
21	Assistant Administrator	3,184	3,248	111,225	34.24	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,040	2,080	43,580	20.95	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)	87,642	89,381	\$ 1,542,374 *	\$ 17.26	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	100	\$ 4,515	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	5,300	11 (3)	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Psychiatric Consultant	monthly	6,000	10 (3)	47
48					48
49	TOTAL (lines 35 - 48)	100	\$ 24,215		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	89	2,152	10 (3)	52
53	TOTAL (lines 50 - 52)	89	\$ 2,152		53

SEE ACCOUNTANTS' PREPARATION REPORT



Facility Name &amp; ID Number WALKER NURSING HOME

# 0021428

Report Period Beginning: 10/01/2016

Ending: 09/30/2017

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IL Nursing Home Admin - \$250
- (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 yrs
- (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. \$ 123,950  
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.
- (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. \$ N/A 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

**SEE ACCOUNTANTS' PREPARATION REPORT**