FOR BHF USE

LL1

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

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0021428

Facility Name: Walker Nursing Home

Address: 530 E Beardstown St (Number) Virginia (City) 62691 (Zip Code)

County: Cass

Telephone Number: (217) 452-3218 **Fax #** (217) 452-7746

HFS ID Number:

Date of Initial License for Current Owners: 01-01-1955

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Roger Hurst **Telephone Number:** (217) 787-9700
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/01/2013 to 09/30/2014 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) Roger Hurst, Partner
(Firm Name & Address) Hurst, Wright & Hafel LLP, 3001 Spring Mill Drive Suite F, Springfield, IL 62704
(Telephone) (217) 787-9700 Fax # (217) 787-2719

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001
Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/01/2013 Ending: 09/30/2014

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF		5,255	1,638	6,893	8
9	SNF/PED					9
10	ICF	8,765			8,765	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,765	5,255	1,638	15,658	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.42%

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 [X] NO [ ]

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

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 [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 71 and days of care provided 1,638

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 09/30/2014 Fiscal Year: 09/30/2014

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/01/2013 Ending: 09/30/2014

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	122,081	7,010	6,146	135,237		135,237		135,237			1
2	Food Purchase		126,540		126,540		126,540		126,540			2
3	Housekeeping	52,564	2,128		54,692		54,692		54,692			3
4	Laundry	53,020	172		53,192		53,192		53,192			4
5	Heat and Other Utilities			73,396	73,396		73,396		73,396			5
6	Maintenance	47,199	16,675	31,925	95,799		95,799		95,799			6
7	Other (specify):*											7
8	**TOTAL General Services**	274,864	152,525	111,467	538,856		538,856		538,856			8
	B. Health Care and Programs											
9	Medical Director			8,400	8,400		8,400		8,400			9
10	Nursing and Medical Records	825,351	57,231	10,259	892,841		892,841		892,841			10
10a	Therapy			302,148	302,148		302,148		302,148			10a
11	Activities	20,708	6,286	5,100	32,094		32,094		32,094			11
12	Social Services	37,904			37,904		37,904		37,904			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Infection Control			9,165	9,165		9,165		9,165			15
16	**TOTAL Health Care and Programs**	883,963	63,517	335,072	1,282,552		1,282,552		1,282,552			16
	C. General Administration											
17	Administrative	115,275			115,275	2,384	117,659		117,659			17
18	Directors Fees											18
19	Professional Services			44,841	44,841		44,841	(1,566)	43,275			19
20	Dues, Fees, Subscriptions & Promotions			15,957	15,957		15,957	(9,282)	6,675			20
21	Clerical & General Office Expenses	43,787	10,545	32,487	86,819		86,819		86,819			21
22	Employee Benefits & Payroll Taxes			172,017	172,017	(2,384)	169,633		169,633			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,094	1,094		1,094		1,094			24
25	Other Admin. Staff Transportation			12,740	12,740		12,740		12,740			25
26	Insurance-Prop.Liab.Malpractice			34,886	34,886		34,886		34,886			26
27	Other (specify):*											27
28	**TOTAL General Administration**	159,062	10,545	314,022	483,629		483,629	(10,848)	472,781			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,317,889	226,587	760,561	2,305,037		2,305,037	(10,848)	2,294,189			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: 10/1/2013** **Ending: 9/30/2014**

Travel & Seminar, Line 24 Col 3	Amount
INAAA (Workshop)	190
Rachel White (CPE)	54
Barnes & Noble (Pharmacy Handbooks)	16
INHAA Workshop (White)	380
PESI Healthcare (Infection Control)	190
Illinois Food Handlers Assc (CPE)	215
Western Schools (RN CPE)	19
Frieberg Press	30
	1,094

Other Admin Staff Transportation Line 25, Col 3	
Fuel	10,444
Vehicle Repairs	2,026
Lodging	130
License	140
	12,740

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Home #0021428 Report Period Beginning: 10/01/2013 Ending: 09/30/2014

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			58,828	58,828		58,828	2,606	61,434			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			837	837		837	(837)				32
33	Real Estate Taxes			23,446	23,446		23,446		23,446			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			3,833	3,833		3,833		3,833			35
36	Other (specify):*											36
37	**TOTAL Ownership**			86,944	86,944		86,944	1,769	88,713			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		42,261		42,261		42,261		42,261			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			131,006	131,006		131,006		131,006			42
43	Other (specify):*			31,663	31,663		31,663	(31,663)				43
44	**TOTAL Special Cost Centers**		42,261	162,669	204,930		204,930	(31,663)	173,267			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,317,889	268,848	1,010,174	2,596,911		2,596,911	(40,742)	2,556,169			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Walker Nursing Home** **# 0021428** **Report Period Beginning: 10/1/2013** **Ending: 9/30/2014**

Other - Line 43, Column 3	Amount
Contributions	375
Advertising	13,681
Non Deductible Expenses	6,059
State Replacement Tax	375
Sales Tax	326
Medicare Services	2,221
Labs - Medicare	8,626
	31,663

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/01/2013 Ending: 09/30/2014

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 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	2,606	30		9
10	Interest and Other Investment Income	(837)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary	(326)	43		12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(375)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,566)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(9,282)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(375)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(30,587)	43		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (40,742)		$	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 Amount	2 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
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (40,742)		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 Yes	2 No	3 Amount	4 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: 10/01/2013

Ending: 09/30/2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Advertising	$ (13,681)	43	1
2	Non-Deductible Expenses	(6,059)	43	2
3	Medicare Services	(2,221)	43	3
4	Labs Medicare	(8,626)	43	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**	(30,587)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Walker Nursing Home # 0021428 **Report Period Beginning:** 10/01/2013 **Ending:** 09/30/2014

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

	Operating Expenses	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)	
	A. General Services													
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	(1,566)	0	0	0	0	0	0	0	0	0	0	(1,566)	19
20	Fees, Subscriptions & Promotions	(9,282)	0	0	0	0	0	0	0	0	0	0	(9,282)	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**	(10,848)	0	0	0	0	0	0	0	0	0	0	(10,848)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(10,848)	0	0	0	0	0	0	0	0	0	0	(10,848)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Walker Nursing Home # 0021428 **Report Period Beginning:** 10/01/2013 **Ending:** 09/30/2014

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	2,606	0	0	0	0	0	0	0	0	0	0	2,606	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(837)	0	0	0	0	0	0	0	0	0	0	(837)	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**	1,769	0	0	0	0	0	0	0	0	0	0	1,769	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):*	(31,663)	0	0	0	0	0	0	0	0	0	0	(31,663)	43
44	**TOTAL Special Cost Centers**	(31,663)	0	0	0	0	0	0	0	0	0	0	(31,663)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(40,742)	0	0	0	0	0	0	0	0	0	0	(40,742)	45

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/01/2013 Ending: 09/30/2014

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
George W. White	50	N/A		N/A		
Mary Ann White	50	N/A		N/A		

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/01/2013 Ending: 09/30/2014

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: 10/01/2013 Ending: 09/30/2014

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mary Ann White	President	Co-Administrator	50.00	0	16	40.00	Salary	$ 15,450	17(1)	1
2			Office Manager			24	60.00	Salary	23,175	21(1)	2
3											3
4	George W. White	Vice President	Co-Administrator	50.00	0	18	45.00	Salary	17,381	17(1)	4
5			Maintenance			22	55.00	Salary	21,244	6(1)	5
6											6
7	Bryan White	None	Asst. Admin	0.00	0	32	80.00	Salary	41,222	17(1)	7
8			Clerical			8	20.00	Salary	10,306	21(1)	8
9											9
10	Rachel White	None	Asst. Admin	0.00	0	26	80.00	Salary	41,222	17(1)	10
11			Clerical			6	20.00	Salary	10,306	21(1)	11
12											12
13								TOTAL	$ 180,306		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: 10/01/2013 Ending: 9/30/2014

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 [X]

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

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/01/2013 Ending: 09/30/2014

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

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' COMPILATION REPORT

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

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/01/2013 Ending: 09/30/2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 18,355	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.)		$ 23,886	2
3. Under or (over) accrual (line 2 minus line 1).		$ 5,531	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 17,914	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.		$ 23,445	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	24,550	8
	2010	25,723	9
	2011	24,832	10
	2012	24,472	11
	2013	23,886	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2013	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

2013 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 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-033-009-00	Lot	$ 510.34	$ 510.34
2.	11-052-009-00	Lot	$ 409.60	$ 409.60
3.	11-087-007-00	Lot	$ 22,966.02	$ 22,966.02
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.	See Accountants'		$	$
10.	Compilation Report		$	$
		TOTALS	$ 23,885.96	$ 23,885.96

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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: 10/01/2013 Ending: 09/30/2014

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? [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.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	22,176	1955	$ 11,000	1
2	Resident Care	9,504	1981	23,604	2
3	TOTALS	31,680		$ 34,604	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/01/2013 Ending: 09/30/2014

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	20		1972	1972	$ 130,523	$	30	$	$	$ 130,523	4
5	30		1977	1977	363,607		30			363,607	5
6	5		1981	1981	79,226		30			79,226	6
7	16		1985	1985	399,782		30	13,326	13,326	386,450	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	7,461	16
17	Leasehold Improvement			1988	2,015	64	Various	66	2	1,733	17
18	Leasehold Improvement			1990	2,480		Various			2,480	18
19	Leasehold Improvement			1991	23,204	1,715	Various	781	(934)	18,044	19
20	Leasehold Improvement			1992	45,806	259	Various	1,504	1,245	34,302	20
21	Leasehold Improvement			1993	11,951	364	Various	374	10	7,918	21
22	Leasehold Improvement			1995	4,939	62	Various	62		4,914	22
23	Leasehold Improvement			1996	6,289		Various			6,289	23
24	Leasehold Improvement			1997	63,654	1,986	Various	2,132	146	36,833	24
25	Leasehold Improvement			1998	45,605	1,169	Various	1,144	(25)	18,375	25
26	Leasehold Improvement			1999	2,066	53	Various	53		819	26
27	Leasehold Improvement			2000	4,528		10			4,528	27
28	Shower Faucets			2000	1,550		10			1,550	28
29	Door Locks			2001	1,500		10			1,500	29
30	Water Heater			2002	4,283		10			4,283	30
31	New Roof			2004	28,437	711	39	729	18	7,519	31
32	Flooring			2005	5,323	133	39	136	3	1,252	32
33	Tiling in Showers			2005	1,062	27	39	27		244	33
34	Sprinkler			2006	860	22	39	22		138	34
35	Fire Alarm System			2007	42,256	1,057	40	1,057		8,064	35
36	Water Line			2007	7,175	179	40	179		1,343	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: 10/01/2013 Ending: 09/30/2014

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Concrete Work for Entrance and Walkways	2007	$ 64,272	$ 3,214	20	$ 3,214	$	$ 17,673	37
38	Manor Landscaping Improvements	2007	10,560	528	20	528		3,948	38
39	Roof Repairs	2006	3,250	163	20	163		1,242	39
40	Toilets & Installation	2008	4,354	218	20	218		3,906	40
41	New Railings	2008	6,315	316	20	316		2,054	41
42	Iron Fence	2008	4,895	245	20	245		1,592	42
43	Major Landscaping	2008	11,701	585	20	585		3,807	43
44	Water Heater	2009	5,998	150	40	150		825	44
45	Air Conditioner 10-ton	2009	9,995	250	40	250		1,375	45
46	Water Heater	2009	5,140	129	40	129		706	46
47	Sprinkler System	2010	45,130	1,541	20	1,541		9,442	47
48	Nurse Call System	2010	48,241	2,412	20	2,412		10,854	48
49	Install Door Alarm System	2011	19,350	484	40	484		1,694	49
50	New Roof on Hall E	2011	31,927	798	40	798		2,793	50
51	Install New Furnace and AC	2011	5,700	143	40	143		500	51
52	Install Dry Valve w/Trim Sprinkler	2011	4,929	123	40	123		431	52
53	New Roof Top	2012	7,790	195	40	195		780	53
54	Furnish and Install Blinds and Valances	2010	9,970	499	20	499		998	54
55	Remove/Replace 3 Doors	2011	2,627	66	40	66		132	55
56	6 New Cooling Units for Resident Rooms	2011	4,246	425	10	425		850	56
57	Generator	2012	58,045	2,902	20	484	(2,418)	968	57
58	Security Cameras	2013	2,726	273	10	273		296	58
59	Tile Flooring - Nurses Station	2013	2,737	68	40	68		74	59
60	New Windows	2013	5,586	140	40	140		175	60
61	Generator	2014	5,081	508	20	254	(254)	254	61
62	New Roof on Shed	2014	7,287	30	40	30		30	62
63	New South Furnace & Cooling System	2014	6,318	13	40	13		13	63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,766,752	$ 24,219		$ 35,542	$ 11,323	$ 1,283,504	70

SEE ACCOUNTANTS' COMPILATION 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: 10/01/2013 Ending: 09/30/2014

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	$ 31,025	$ 25,284	$ (5,741)		$ 160,665	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	614,120					614,120	73
74								74
75	TOTALS	$ 867,434	$ 31,025	$ 25,284	$ (5,741)		$ 774,785	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	1,857	464	(1,393)		464	77
78	Resident Care	Recondition Bus	2014	12,090	1,727	144	(1,583)		144	78
79										79
80	TOTALS			$ 70,072	$ 3,584	$ 608	$ (2,976)		$ 45,591	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)	$ 2,738,862	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 58,828	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 61,434	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 2,606	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,103,880	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: 10/01/2013 Ending: 09/30/2014

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

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: *

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.	/2015	$
13.	/2016	$
14.	/2017	$

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: $ 3,833 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: 10/1/2013** **Ending: 9/30/2014**

Schedule 14A

XII. Rental Costs

Line 16 - Description

Ice Machine	1,484
Dishwasher	1,306
Copy Machine	925
Floor Scrubber	118
Total Agreeing with P4, L35, C3	3,833

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/01/2013 Ending: 09/30/2014

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
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

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/01/2013 Ending: 09/30/2014

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10A, C3	hrs	$	1,887	$ 139,258	$	1,887	$ 139,258	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		256	18,911		256	18,911	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		1,951	143,979		1,951	143,979	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				41,815		41,815	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):	L10, C3				10,259			10,259	12
13	Other (specify):									13
14	TOTAL			$	4,094	$ 312,407	$ 41,815	4,094	$ 354,222	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

STATE OF ILLINOIS

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/01/2013 Ending: 09/30/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 09/30/2014 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 154,663	$ 154,663	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	516,553	516,553	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	186,724	186,724	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	3,293	3,293	7
8	Accounts Receivable (owners or related parties)	105,992	105,992	8
9	Other(specify): Employee Advances	3,898	3,898	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 971,123	$ 971,123	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	690,954	793,614	15
16	Equipment, at Historical Cost	1,017,669	937,506	16
17	Accumulated Depreciation (book methods)	(2,102,200)	(2,103,880)	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): Sec 444 Deposit	22,855	22,855	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 685,934	$ 657,837	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,657,057	$ 1,628,960	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 137,989	$ 137,989	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	58,567	58,567	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	17,914	17,914	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	3,314	3,314	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 217,784	$ 217,784	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)**	$ 217,784	$ 217,784	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,439,273	$ 1,411,176	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,657,057	$ 1,628,960	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number **Walker Nursing Home** **# 0021428** **Report Period Beginning: 10/1/2013** **Ending: 9/30/2014**

Schedule 17A

Line 36 - Other Current Liabilities

	Operating	After Consolidation
State Unemployment Payable	3,019	3,019
Federal Unemployment Payable	295	295
	3,314	3,314

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/01/2013 Ending: 09/30/2014

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,543,285	1
2	Restatements (describe):		2
3	State Replacement Tax	1,635	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,544,920	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	22,023	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	(127,670)	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)**	$ (105,647)	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)**	$ 1,439,273	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/01/2013 Ending: 09/30/2014

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,625,730	1
2	Discounts and Allowances for all Levels	(14,003)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,611,727	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***	6,275	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 6,275	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Void Outstanding Checks	932	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 932	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,618,934	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	538,856	31
32	Health Care	1,282,552	32
33	General Administration	483,629	33
	B. Capital Expense		
34	Ownership	86,944	34
	C. Ancillary Expense		
35	Special Cost Centers	73,924	35
36	Provider Participation Fee	131,006	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,596,911	40
41	**Income before Income Taxes (line 30 minus line 40)****	22,023	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 22,023	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 835,185	44
45	Private Pay - Net Inpatient Revenue	1,221,061	45
46	Medicare - Net Inpatient Revenue	555,481	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,611,727	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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: 10/01/2013 Ending: 09/30/2014

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,026	2,129	$ 66,654	$ 31.31	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,927	3,992	102,234	25.61	3
4	Licensed Practical Nurses	14,479	15,121	321,227	21.24	4
5	CNAs & Orderlies	30,476	31,561	333,607	10.57	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,792	1,900	20,230	10.65	9
10	Activity Assistants					10
11	Social Service Workers	1,942	2,048	39,533	19.30	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,011	2,140	40,008	18.70	14
15	Cook Helpers/Assistants	8,263	8,633	82,073	9.51	15
16	Dishwashers					16
17	Maintenance Workers	3,304	3,392	47,199	13.91	17
18	Housekeepers	5,310	5,519	52,564	9.52	18
19	Laundry	5,003	5,357	53,020	9.90	19
20	Administrator	1,802	1,802	32,831	18.22	20
21	Assistant Administrator	3,392	3,392	82,826	24.42	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,120	2,120	43,883	20.70	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)	85,847	89,106	$ 1,317,889 *	$ 14.79	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	153	$ 6,146	1(3)	35
36	Medical Director	Monthly	8,400	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	5,100	11(3)	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	153	$ 19,646		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	201	8,693	10(3)	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	201	$ 8,693		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/01/2013 Ending: 09/30/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
George W. White	Co-Administrator	50	$ 17,381
Mary Ann White	Co-Administrator	50	15,450
Bryan White	Asst. Admin	0	41,222
Rachel White	Asst. Admin	0	41,222
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 115,275

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Cavanagh & O'Hara	Legal Services	$ 5,671
CHC	Deleware Rep	1,055
Hurst, Wright & Hafel LLP	Accounting	35,915
RSM/M&P	Accounting	200
R.W. Troxell	Workmen's Comp Service	2,000
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 44,841

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 30,731
Unemployment Compensation Insurance	19,837
FICA Taxes	99,640
Employee Health Insurance	18,755
Employee Meals	535
Illinois Municipal Retirement Fund (IMRF)*	
Employee Medical Services	135
TOTAL (agree to Schedule V, line 22, col.8)	$ 169,633

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,694
Health Care Worker Background Check	
(Indicate # of checks performed 11)	342
Patient Background Checks 45	450
Public Relations	9,282
Other Subscriptions & Licenses	2,189
Less: Public Relations Expense	(9,282)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,675

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,094
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,094

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/01/2013 Ending: 09/30/2014

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	Amount of Expense Amortized Per Year								
					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:** 10/01/2013 **Ending:** 09/30/2014

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? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line **10(2)**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **131,006**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes - Pg7** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **535** 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 maintaned**
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 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.