FOR BHF USE

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2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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

I. IDPH License ID Number: 0021428

Facility Name: WALKER NURSING HOME

Address: 530 EAST BEARDSTOWN (Number) VIRGINIA (City) 62691 (Zip Code)

County: CASS

Telephone Number: 217-425-3218 **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:** 217-789-0960
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 10/01/17 to 9/30/18 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) 1/2/19 (Date)
(Type or Print Name) RACHEL WHITE
(Title) ADMINISTRATOR

Paid Preparer

(Signed) 1/2/19 (Date)
(Print Name and Title) ROGER HURST, SENIOR TAX MANAGER
(Firm Name & Address) Kerber, Eck & Braeckel LLP, 3200 Robbins Rd, Ste 200A, Springfield, IL 62704
(Telephone) 217-789-0960 Fax # 217-789-2822

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' PREPARATION REPORT

Facility Name & ID Number WALKER NURSING HOME # 0021428 Report Period Beginning: 10/01/17 Ending: 9/30/18

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 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		6,494	1,191	7,685	8
9	SNF/PED					9
10	ICF	6,672			6,672	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,672	6,494	1,191	14,357	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 55.40%

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 [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 1,191

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: 09/30/18 Fiscal Year: 09/30/18

* 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: 10/01/17 Ending: 9/30/18

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	145,892	45	4,674	150,611		150,611		150,611			1
2	Food Purchase		120,418		120,418		120,418		120,418			2
3	Housekeeping	60,977	3,948		64,925		64,925		64,925			3
4	Laundry	52,856	38		52,894		52,894		52,894			4
5	Heat and Other Utilities			63,676	63,676		63,676		63,676			5
6	Maintenance	52,862	9,093	40,948	102,903		102,903		102,903			6
7	Other (specify):*											7
8	**TOTAL General Services**	312,587	133,542	109,298	555,427		555,427		555,427			8
	B. Health Care and Programs											
9	Medical Director			7,300	7,300		7,300		7,300			9
10	Nursing and Medical Records	1,027,460	56,747	6,494	1,090,701		1,090,701		1,090,701			10
10a	Therapy			234,570	234,570		234,570		234,570			10a
11	Activities	41,341	450	5,100	46,891		46,891		46,891			11
12	Social Services	41,884			41,884		41,884		41,884			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* **Infection Control**			6,276	6,276		6,276		6,276			15
16	**TOTAL Health Care and Programs**	1,110,685	57,197	259,740	1,427,622		1,427,622		1,427,622			16
	C. General Administration											
17	Administrative	122,935			122,935		122,935		122,935			17
18	Directors Fees											18
19	Professional Services			28,693	28,693		28,693	(1,415)	27,278			19
20	Dues, Fees, Subscriptions & Promotions			7,089	7,089		7,089	(2,318)	4,771			20
21	Clerical & General Office Expenses	15,089	11,092	36,174	62,355		62,355		62,355			21
22	Employee Benefits & Payroll Taxes			206,144	206,144		206,144		206,144			22
23	Inservice Training & Education			10,227	10,227		10,227		10,227			23
24	Travel and Seminar			125	125		125		125			24
25	Other Admin. Staff Transportation			10,134	10,134		10,134		10,134			25
26	Insurance-Prop.Liab.Malpractice			26,694	26,694		26,694		26,694			26
27	Other (specify):*											27
28	**TOTAL General Administration**	138,024	11,092	325,280	474,396		474,396	(3,733)	470,663			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,561,296	201,831	694,318	2,457,445		2,457,445	(3,733)	2,453,712			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.

Facility Name & ID Number WALKER NURSING HOME **#** 0021428 **Report Period Beginning:** 10/01/17 **Ending:** 9/30/18

Inservice Training & Education - Line 23 (3)	Amount
American Ambulance - CPR Classes	180
Briggs HealthCare Corp - Learning Materials	135
Health Care Academy - Course Licenses	2,500
Pathway Health - Rehab Course	2,598
Reliance Learning - Monthly Staff Training videos	4,658
Other vendors for handbooks & slides purchased	156
	10,227

Travel and Seminar - Line 24 (3)	Amount
IL NHAA Meetings	125
	125

Other Admin. Staff Travel & Transportation - Line 25 (3)	Amount
Fuel	8,931
Vehicle Repairs	1,202
	10,133

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number WALKER NURSING HOME #0021428 Report Period Beginning: 10/01/17 Ending: 9/30/18

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			52,361	52,361		52,361	1,645	54,006			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			25,355	25,355		25,355		25,355			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			3,762	3,762		3,762		3,762			35
36	Other (specify):*											36
37	**TOTAL Ownership**			81,478	81,478		81,478	1,645	83,123			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		26,465		26,465		26,465		26,465			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			118,789	118,789		118,789		118,789			42
43	Other (specify):*			32,886	32,886		32,886	(32,886)				43
44	**TOTAL Special Cost Centers**		26,465	151,675	178,140		178,140	(32,886)	145,254			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,561,296	228,296	927,471	2,717,063		2,717,063	(34,974)	2,682,089			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

Facility Name & ID Number **WALKER NURSING HOME** **# 0021428** **Report Period Beginning: 10/01/17** **Ending: 9/30/18**

Other - Line 43, Column 3	Amount
Sales Tax	409
Contributions	250
Advertising	19,616
Medicare Services	5,036
Labs - Medicare	7,566
Penalities	9
	32,886

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number WALKER NURSING HOME # 0021428 Report Period Beginning: 10/01/17 Ending: 9/30/18

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	1,645	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	(409)	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	(9)	43		18
19	Entertainment				19
20	Contributions	(250)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,415)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,318)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(32,218)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (34,974)		$	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))**	$ (34,974)		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' PREPARATION REPORT

WALKER NURSING HOME

ID# 0021428

Report Period Beginning: 10/01/17

Ending: 9/30/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Advertising	$ (19,616)	43	1
2	Medicare Services	(5,036)	43	2
3	Labs - Medicare	(7,566)	43	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
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**	(32,218)		49

Facility Name & ID Number WALKER NURSING HOME # 0021428 Report Period Beginning: 10/01/17 Ending: 9/30/18

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' PREPARATION REPORT

Facility Name & ID Number WALKER NURSING HOME # 0021428 Report Period Beginning: 10/01/17 Ending: 9/30/18

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	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Mary Ann White	President	Clerical	50.00	0	40	100.00	Salary	$ 750	21 (1)	1
2											2
3											3
4	George W White	Vice-President	Maintenance	50.00	0	40	100.00	Salary	24,066	6 (1)	4
5											5
6											6
7	Bryan White	none	Asst. Admin	0.00	0	32	80.00	Salary	57,357	17 (1)	7
8			Clerical			8	20.00	Salary	14,339	21 (1)	8
9											9
10	Rachel White	none	Administrator	0.00	0	40	100.00	Salary	65,578	17 (1)	10
11											11
12											12
13								TOTAL	$ 162,090		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

Facility Name & ID Number WALKER NURSING HOME # 0021428 Report Period Beginning: 10/01/17 Ending: 9/30/18

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		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: 10/01/17 Ending: 9/30/18

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	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' PREPARATION 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: 10/01/17 Ending: 9/30/18

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 18,193	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.)		$ 24,884	2
3. Under or (over) accrual (line 2 minus line 1).		$ 6,691	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 18,663	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.		$ 25,354	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	23,886	8
	2014	23,784	9
	2015	23,970	10
	2016	24,258	11
	2017	24,884	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 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 2017 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 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-033-009-00	Lot	$ 528.94	$ 528.94
2.	11-052-009-00	Lot	$ 427.00	$ 427.00
3.	11-087-007-00	Lot	$ 23,928.50	$ 23,928.50
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 24,884.44	$ 24,884.44

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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: 10/01/17 Ending: 9/30/18

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.

	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' PREPARATION REPORT

Facility Name & ID Number WALKER NURSING HOME # 0021428 Report Period Beginning: 10/01/17 Ending: 9/30/18

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			399,782	7
8											8
	Improvement Type**										
9	Leasehold Improvement			1974	900		Various			900	9
10	Leasehold Improvement			1975	200		Various			200	10
11	Leasehold Improvement			1977	2,889		Various			2,889	11
12	Leasehold Improvement			1982	552		Various			552	12
13	Leasehold Improvement			1983	533		Various			533	13
14	Leasehold Improvement			1984	11,510		Various			11,510	14
15	Leasehold Improvement			1985	70,113		Various			70,113	15
16	Leasehold Improvement			1986	7,764		Various			7,764	16
17	Leasehold Improvement			1988	2,015	67	Various	67		2,000	17
18	Leasehold Improvement			1990	2,480		Various			2,480	18
19	Leasehold Improvement			1991	23,204	519	Various	773	254	20,890	19
20	Leasehold Improvement			1992	45,806	1,455	Various	1,527	72	40,315	20
21	Leasehold Improvement			1993	11,951	314	Various	306	(8)	9,218	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	42,737	24
25	Leasehold Improvement			1998	45,605	1,169	Various	1,169		23,026	25
26	Leasehold Improvement			1999	2,066	53	Various	53		1,031	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	10,417	30
31	Flooring			2005	5,323	133	39	136	3	1,793	31
32	Tiling in Showers			2005	1,062	27	39	27		352	32
33	Sprinkler			2006	860	22	39	22		226	33
34	Roof Repairs			2006	3,250	165	20	163	(2)	1,896	34
35	Fire Alarm System			2007	42,256	1,057	40	1,056	(1)	12,290	35
36	Water Line			2007	7,175	179	40	179		2,059	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**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: 10/01/17 Ending: 9/30/18

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	$	$ 30,529	37
38	Manor Landscaping Improvements	2007	10,560	528	20	528		6,060	38
39	Toilets & Installation	2008	4,354		20			4,354	39
40	New Railings	2008	6,315	158	20	162	4	2,852	40
41	Iron Fence	2008	4,895	245	20	245		2,572	41
42	Major Landscaping	2008	11,701	586	20	585	(1)	6,148	42
43	Water Heater	2009	5,998	150	40	150		1,425	43
44	Air Conditioner - 10 ton	2009	9,995	250	40	250		2,375	44
45	Water Heater	2009	5,140	129	40	129		1,222	45
46	Sprinkler Systems	2010	45,130	1,218	20	2,257	1,039	16,715	46
47	Nurse Call System	2010	48,241	2,412	20	2,412		20,502	47
48	Furnish & Install Blinds & Valances	2010	9,970	499	20	499		2,994	48
49	Install Door Alarm System	2011	19,350	484	40	484		3,630	49
50	New Roof on Hall E	2011	31,927	798	40	798		5,985	50
51	Install New Furnace & Air Conditioner	2011	5,700	143	40	143		1,072	51
52	Install Dry Valve w/ Trim Sprinkler	2011	4,929	123	40	123		923	52
53	Remove/replace 3 doors	2011	2,627	66	40	66		396	53
54	6 New Cooling Units for Resident Rooms	2011	4,246	425	10	425		2,550	54
55	Generator	2012	58,045	2,902	20	2,902		10,158	55
56	New Roof Top	2012	7,790	195	40	195		1,560	56
57	Security Cameras	2013	2,726	273	10	273		1,388	57
58	Tile Flooring - Nurses Station	2013	2,737	68	40	68		346	58
59	New Windows	2013	5,586	140	40	140		735	59
60	Generator	2014	5,081	468	20	254	(214)	1,484	60
61	New Roof on Shed	2014	7,287	182	40	182		758	61
62	New South Furnace & Cooling System	2014	6,318	158	40	158		645	62
63	New Energy Control System	2015	11,338	756	20	567	(189)	1,937	63
64	New Roof Top A/C Unit	2015	11,640	776	20	582	(194)	1,989	64
65	New Brick Wall & Concrete Work	2016	3,425	171	20	171		499	65
66	New Roof A/C	2016	3,634	242	20	182	(60)	469	66
67	New Tile & Installation - North Hall	2017	5,627	141	40	141		270	67
68	New Water Heater & Installation	2017	8,656	866	10	866		1,587	68
69	North Hall - New Water Heater & Install	2017	8,615	862	10	862		1,221	69
70	TOTAL (lines 4 thru 69)		$ 1,819,687	$ 26,755		$ 27,478	$ 723	$ 1,398,768	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: 10/01/17 Ending: 9/30/18

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	$ 178,316	$ 21,667	$ 21,901	$ 234	various	$ 150,625	71
72	Current Year Purchases	12,516	1,252	1,043	(209)	10	1,252	72
73	Fully Depreciated Assets	725,680				various	725,680	73
74								74
75	TOTALS	$ 916,512	$ 22,919	$ 22,944	$ 25		$ 877,557	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	$	$	$	5	$ 44,983	76
77	Resident Care	2008 Chevy Van	2014	12,999	1,392	1,857	465	7	7,273	77
78	Resident Care	Recondition Bus	2014	12,090	1,295	1,727	432	7	6,476	78
79										79
80	TOTALS			$ 70,072	$ 2,687	$ 3,584	$ 897		$ 58,732	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)	$ 2,840,875	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 52,361	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 54,006	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 1,645	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,335,057	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.

Facility Name & ID Number WALKER NURSING HOME # 0021428 Report Period Beginning: 10/01/17 Ending: 9/30/18

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	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.	/2019	$
13.	/2020	$
14.	/2021	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ 3,762 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	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' PREPARATION REPORT

Facility Name & ID Number WALKER NURSING HOME # 0021428 **Report Period Beginning:** 10/01/17 **Ending:** 9/30/18

Schedule 14A

XII. Rental Costs
Line 16 - Description

Ice Machine	1,440
Dishwasher	759
Copy Machine	1,244
Small Tools	319
	3,762

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number WALKER NURSING HOME # 0021428 Report Period Beginning: 10/01/17 Ending: 9/30/18

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' PREPARATION REPORT

Facility Name & ID Number WALKER NURSING HOME # 0021428 Report Period Beginning: 10/01/17 Ending: 9/30/18

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	$	1,591	$ 118,612	$	1,591	$ 118,612	1
2	Licensed Speech and Language Development Therapist	L10A C3	hrs		175	13,558		175	13,558	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A C3	hrs		1,296	102,400		1,296	102,400	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				26,465		26,465	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$	3,062	$ 234,570	$ 26,465	3,062	$ 261,035	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

STATE OF ILLINOIS

Facility Name & ID Number WALKER NURSING HOME # 0021428 Report Period Beginning: 10/01/17 Ending: 9/30/18

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 9/30/18 (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	$ 83,117	$ 83,117	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	537,858	537,858	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	194,789	194,789	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	106,992	106,992	8
9	Other(specify): Employee Loans	5,100	5,100	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 927,856	$ 927,856	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	743,888	846,550	15
16	Equipment, at Historical Cost	1,066,746	986,584	16
17	Accumulated Depreciation (book methods)	(2,321,219)	(2,336,702)	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):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 546,071	$ 504,174	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,473,927	$ 1,432,030	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 96,679	$ 96,679	26
27	Officer's Accounts Payable	10,760	10,760	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	36,772	36,772	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	18,663	18,663	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 162,874	$ 162,874	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)**	$ 162,874	$ 162,874	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,311,053	$ 1,269,156	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,473,927	$ 1,432,030	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name & ID Number WALKER NURSING HOME # 0021428 Report Period Beginning: 10/01/17 Ending: 9/30/18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,343,400	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,343,400	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(32,347)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (32,347)	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)**	$ 1,311,053	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number WALKER NURSING HOME # 0021428 Report Period Beginning: 10/01/17 Ending: 9/30/18

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	$ 2,703,197	1
2	Discounts and Allowances for all Levels	(24,398)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,678,799	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***	4,204	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,204	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Refunds	1,713	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,713	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,684,716	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	555,427	31
32	Health Care	1,427,622	32
33	General Administration	474,396	33
	B. Capital Expense		
34	Ownership	81,478	34
	C. Ancillary Expense		
35	Special Cost Centers	178,140	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,717,063	40
41	**Income before Income Taxes (line 30 minus line 40)****	(32,347)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (32,347)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 525,995	44
45	Private Pay - Net Inpatient Revenue	1,469,623	45
46	Medicare - Net Inpatient Revenue	510,846	46
47	Other-(specify) Insurance Revenue	172,335	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,678,799	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: 10/01/17 Ending: 9/30/18

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	411	457	$ 17,721	$ 38.78	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,527	7,698	247,103	32.10	3
4	Licensed Practical Nurses	11,919	12,298	318,199	25.87	4
5	CNAs & Orderlies	31,165	32,038	444,437	13.87	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,730	3,824	41,341	10.81	9
10	Activity Assistants					10
11	Social Service Workers	1,920	1,972	41,884	21.24	11
12	Dietician					12
13	Food Service Supervisor	2,097	2,144	43,102	20.10	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,748	9,957	102,790	10.32	15
16	Dishwashers					16
17	Maintenance Workers	3,200	3,272	52,862	16.16	17
18	Housekeepers	5,407	5,534	60,977	11.02	18
19	Laundry	4,213	4,316	52,856	12.25	19
20	Administrator	2,040	2,086	65,578	31.44	20
21	Assistant Administrator	1,632	1,668	57,357	34.39	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	488	497	15,089	30.36	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)	85,497	87,761	$ 1,561,296 *	$ 17.79	34

SEE ACCOUNTANTS' PREPARATION REPORT

* 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	92	$ 4,674	1 (3)	35
36	Medical Director	Monthly	7,300	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	Psychiatric Consultant	Monthly	6,000	10 (3)	47
48					48
49	TOTAL (lines 35 - 48)	92	$ 23,074		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				51
52	Certified Nurse Assistants/Aides	19	494	10 (3)	52
53	TOTAL (lines 50 - 52)	19	$ 494		53

Facility Name & ID Number WALKER NURSING HOME # 0021428 Report Period Beginning: 10/01/17 Ending: 9/30/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Rachel White	Administrator		$ 65,578
Bryan White	Asst. Administrator		57,357
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 122,935

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	$ 1,415
Kerber, Eck & Braeckel LLP	Accounting	26,665
RSM US LLP	Consulting - Public Aid	425
	Audit	
Cogency Global Inc	Annual Corp Report	188
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 28,693

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 32,357
Unemployment Compensation Insurance	9,846
FICA Taxes	132,201
Employee Health Insurance	30,482
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	0
Employee Benefits	1,084
Employee Medical Services	174
TOTAL (agree to Schedule V, line 22, col.8)	$ 206,144

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	2,655
Health Care Worker Background Check	103
(Indicate # of checks performed 1)	29
Patient Background Checks 25	250
Public Relations	2,318
Other License fees	833
Association Dues	100
Subscriptions	801
Less: Public Relations Expense	(2,318)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,771

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
(See page 3A)	125
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 125

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number WALKER NURSING HOME # 0021428 Report Period Beginning: 10/01/17 Ending: 9/30/18

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 - $125**

(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. $ **118,789**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes - Pg 7** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' PREPARATION 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. $ **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 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.