

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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: 0050468 Facility Name: Walnut Grove Village Address: 1095 Twilight Drive Morris 64050 Number City Zip Code County: Grundy Telephone Number: (815) 942-5108 Fax # (815) 942-6877 HFS ID Number: Date of Initial License for Current Owners: 08/01/09 Type of Ownership: ☐ VOLUNTARY,NON-PROFIT ☐ Charitable Corp. ☐ Trust IRS Exemption Code ☒ PROPRIETARY ☐ Individual ☐ Partnership ☐ Corporation ☐ "Sub-S" Corp. ☒ Limited Liability Co. ☐ Trust ☐ Other ☐ GOVERNMENTAL ☐ State ☐ County ☐ Other

In the event there are further questions about this report, please contact:

Name: Michael W. Martin Telephone Number: (217) 258-8888

Email Address:

Facility Name & ID Number Walnut Grove Village

0050468 Report Period Beginning: 01/01/11 Ending: 12/31/11

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>123</u>	Skilled (SNF)	<u>123</u>	<u>44,895</u>	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	<u>123</u>	TOTALS	<u>123</u>	<u>44,895</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>16,650</u>	<u>9,644</u>	<u>9,667</u>	<u>35,961</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>16,650</u>	<u>9,644</u>	<u>9,667</u>	<u>35,961</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.10%

D. How many bed-hold days during this year were paid by the Department? 0 (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)
N/A

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☒ NO ☐ Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

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

I. On what date did you start providing long term care at this location?
Date started 08/01/09

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 08/01/09 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 35 and days of care provided 6,900

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/11 Fiscal Year: 12/31/11

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

STATE OF ILLINOIS

Facility Name & ID Number

Walnut Grove Village

0050468

Report Period Beginning:

01/01/11

Ending:

12/31/11

Page 3

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	206,729	42,887	11,075	260,691		260,691		260,691			1
2	Food Purchase		233,114		233,114		233,114	(10,551)	222,563			2
3	Housekeeping	190,209	20,821	220	211,250		211,250		211,250			3
4	Laundry	59,740	27,224		86,964		86,964		86,964			4
5	Heat and Other Utilities			104,917	104,917		104,917	3,668	108,585			5
6	Maintenance	65,701	20,825	121,245	207,771		207,771	(9,485)	198,286			6
7	Other (specify):*											7
8	TOTAL General Services	522,379	344,871	237,457	1,104,707		1,104,707	(16,368)	1,088,339			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	2,427,445	192,089	23,190	2,642,724		2,642,724		2,642,724			10
10a	Therapy	5,733	619	769,266	775,618		775,618		775,618			10a
11	Activities	77,780	2,777	1,695	82,252		82,252		82,252			11
12	Social Services	52,780		397	53,177		53,177		53,177			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,563,738	195,485	812,548	3,571,771		3,571,771		3,571,771			16
	C. General Administration											
17	Administrative	80,649		399,298	479,947		479,947	(399,298)	80,649			17
18	Directors Fees											18
19	Professional Services			61,899	61,899		61,899	9,215	71,114			19
20	Dues, Fees, Subscriptions & Promotions			4,378	4,378		4,378	6,774	11,152			20
21	Clerical & General Office Expenses	127,475	40,222	28,994	196,691		196,691	250,310	447,001			21
22	Employee Benefits & Payroll Taxes			500,301	500,301		500,301	9,508	509,809			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,059	3,059		3,059	844	3,903			24
25	Other Admin. Staff Transportation			48,958	48,958		48,958	(29,222)	19,736			25
26	Insurance-Prop.Liab.Malpractice			92,238	92,238		92,238	2,232	94,470			26
27	Other (specify):* HO Alloc - Benefits							36,440	36,440			27
28	TOTAL General Administration	208,124	40,222	1,139,125	1,387,471		1,387,471	(113,197)	1,274,274			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,294,241	580,578	2,189,130	6,063,949		6,063,949	(129,565)	5,934,384			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			27,529	27,529		27,529	5,274	32,803			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			62	62		62	7,198	7,260			32
33	Real Estate Taxes			133,088	133,088		133,088	1,088	134,176			33
34	Rent-Facility & Grounds			819,996	819,996		819,996		819,996			34
35	Rent-Equipment & Vehicles			36,910	36,910		36,910	11,638	48,548			35
36	Other (specify):*											36
37	TOTAL Ownership			1,017,585	1,017,585		1,017,585	25,198	1,042,783			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		283,797		283,797		283,797		283,797			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			68,544	68,544		68,544		68,544			42
43	Other (specify):* Non-Allow Costs			220,176	220,176		220,176	(220,176)				43
44	TOTAL Special Cost Centers		283,797	288,720	572,517		572,517	(220,176)	352,341			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,294,241	864,375	3,495,435	7,654,051		7,654,051	(324,543)	7,329,508			45

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

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	5,274	30		9
10	Interest and Other Investment Income	(314)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				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				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				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 See Pg 5A	(265,779)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (260,819)		\$	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)	(63,724)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (63,724)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (324,543)		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

Walnut Grove Village

	ID#	0050468
Report Period Beginning:		01/01/11
Ending:		12/31/11

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1		\$		1
2	Advertising	(3,466)	43	2
3	Radiology	(12,337)	43	3
4	Laboratory	(20,555)	43	4
5				5
6	Promotional Advertising	(6,990)	43	6
7	Marketing/Sales - Other	(5,598)	43	7
8	Penalties/Fines	(34,490)	43	8
9	Other Bad Debts	(130,100)	43	9
10	Television	(5,410)	43	10
11	Personal Property Taxes	(1,200)	43	11
12	Disallow non-allowable interest expense	(62)	32	12
13				13
14				14
15	Vending Machine Revenue offset	(1,043)	2	15
16	Nonallowable Legal	(1,309)	19	16
17	Capitalize Repairs Expenses	(14,057)	6	17
18	Adj Real Estate Taxes	1,088	33	18
19	Non coded expense	(30)	43	19
20	Non allowable travel	(648)	24	20
21	Non allowable chamber dues	(350)	20	21
22	Non allowable airplane expenses	(29,222)	25	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	(265,779)		49

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Morris Sterling Holdings, LLC	100	Mountain Ridge Wellness Center	North Carolina	Coventry Cottages	Sterling, IL	Asst. Living
		Clemmons Nursing & Rehab	North Carolina	Walnut Grove Cottage	Morris	Asst. Living
		Windsor Care Center	Kentucky	N100LW, LLC	HICKORY, NC	AIRPLANE ENTIT
		Blounstown Health & Rehab	Florida	DMG AERO, LLC	HICKORY, NC	AIRPLANE ENTIT
		Coventry Living Center	Sterling, IL			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Management Fees	\$ 399,298	WW Healthcare Consultants, LLC		\$	\$(399,298)	1
2	V	21	Salaries/Wages		WW Healthcare Consultants, LLC		201,713	201,713	2
3	V	27	Employee Benefits		WW Healthcare Consultants, LLC		36,440	36,440	3
4	V	21	Clerical/General-Other		WW Healthcare Consultants, LLC		46,526	46,526	4
5	V	19	Professional Services		WW Healthcare Consultants, LLC		10,524	10,524	5
6	V								6
7	V	20	Dues/Subs/Licenses		WW Healthcare Consultants, LLC		3,844	3,844	7
8	V								8
9	V	24	Travel/Seminar		WW Healthcare Consultants, LLC		1,492	1,492	9
10	V	21	Office/Other Supplies		WW Healthcare Consultants, LLC		5,351	5,351	10
11	V	32	Interest		WW Healthcare Consultants, LLC		7,574	7,574	11
12	V	26	Insurance		WW Healthcare Consultants, LLC		2,232	2,232	12
13	V	6	Maintenance Supplies		WW Healthcare Consultants, LLC		2,648	2,648	13
14	Total			\$ 399,298			\$ 318,344	\$ * \$(80,954)	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	Maintenance Repairs & Other	\$	WW Healthcare Consultants, LLC		\$ 1,924	\$ 1,924	15
16	V	35	Rent		WW Healthcare Consultants, LLC		11,638	11,638	16
17	V	5	Utilities		WW Healthcare Consultants, LLC		3,668	3,668	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 17,230	\$ * 17,230	39

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

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	
					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	
	Name	Title	Function	Ownership Interest		Hours	Percent	Description	Amount		
1	Steven D Womack	Owner	Administrative	70.00	185,080	8.74	17.49	Salary	\$ 39,232	21(1)	1
2	Melvin E Woodward	Owner	Administrative	30.00	123,996	8.74	17.49	Salary	26,284	21(1)	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 65,516		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

Walnut Grove Village

Sch 7A

Provider # 0050468

FYE: 12/31/11

Related Nursing Facilities

	Salaries		Hours Worked	% of Total Hours
	Steve Womack	Melvin Woodward		
Regency Care of Black Mountain	36,863	24,697	8.22	16.43%
Regency Care of Clemmons	29,248	19,595	6.52	13.04%
Regency Care of Mt. Sterling	52,156	34,943	11.63	23.25%
Regency Care of Blountstown	23,893	16,007	5.33	10.65%
Sterling SNF Management LLC	31,365	21,014	6.99	13.98%
Morris SNF Management	39,232	26,284	8.74	17.49%
BHI LLC	11,555	7,741	2.58	5.15%
	224,312	150,280	50.00	100.00%

Facility Name & ID Number Walnut Grove Village # 0050468 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization WW Healthcare Consultants, LLC
Street Address 1978 8th Avenue NW
City / State / Zip Code Hickory, NC 28601
Phone Number (828) 381-4923
Fax Number (828) 322-9598

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	21	Salaries/Wages	Patient Days	156,062	7	\$ 1,153,319	\$ 1,153,319	27,295	\$ 201,713	1
2	27	Employee Benefits	Patient Days	156,062	7	208,351		27,295	36,440	2
3	21	Clerical/General-Other	Patient Days	156,062	7	266,020		27,295	46,526	3
4	19	Professional Services	Patient Days	156,062	7	60,171		27,295	10,524	4
5										5
6	20	Dues/Subs/Licenses	Patient Days	156,062	7	21,979		27,295	3,844	6
7										7
8	24	Travel/Seminar	Patient Days	156,062	7	8,528		27,295	1,492	8
9	21	Office/Other Supplies	Patient Days	156,062	7	30,594		27,295	5,351	9
10	32	Interest	Patient Days	156,062	7	43,304		27,295	7,574	10
11	26	Insurance	Patient Days	156,062	7	12,764		27,295	2,232	11
12	6	Maintenance Supplies	Patient Days	156,062	7	15,141		27,295	2,648	12
13	6	Maintenance Repairs & Other	Patient Days	156,062	7	10,999		27,295	1,924	13
14	35	Rent	Patient Days	156,062	7	66,539		27,295	11,638	14
15	5	Utilities	Patient Days	156,062	7	20,972		27,295	3,668	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,918,680	\$ 1,153,319		\$ 335,574	25

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	I.D.E.S. Interest											62	8
9	TOTAL Facility Related						\$					\$ 62	9
	B. Non-Facility Related*												
10													10
11							Disallow nonallowable interest					(62)	11
12							HO Interest Allocation					7,574	12
13							Interest Income Offset					(314)	13
14	TOTAL Non-Facility Related						\$					\$ 7,198	14
15	TOTALS (line 9+line14)						\$					\$ 7,260	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.)

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	205,532	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.)		2010		\$	121,856	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(83,676)	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	217,852	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.				\$	134,176	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2006	_____	8		
		2007	_____	9		
		2008	_____	10		
		2009	122,435	11		
		2010	121,856	12		
Accrual + 1.06% of prior year.						

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	\$	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

FACILITY NAME Walnut Grove Village COUNTY Grundy

FACILITY IDPH LICENSE NUMBER 0050468

CONTACT PERSON REGARDING THIS REPORT Gene Woodard

TELEPHONE (828) 322-4285 FAX #: (828) 322-9598

Enter the tax index number and real estate tax assessed for 2010 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 2010.

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

46,744

B. General Construction Type:

Exterior

Brick

Frame

Wood

Number of Stories

One

C. Does the Operating Entity?

☐

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☒

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

30 Cottages - Cost not included in cost report

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

N/A

2. Number of Years Over Which it is Being Amortized:

N/A

3. Current Period Amortization:

N/A

4. Dates Incurred:

N/A

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1			N/A	\$	1
2					2
3	TOTALS			\$	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9										9
10		Focus Fire	2009		6,096	1,219	5	1,219		3,048
11		Flooring	2009		3,774	755	5	755		1,887
12		Landscaping-Lava Rock	2009		6,723	672	10	672		1,680
13		Carpet	2009		3,183	636	5	637	1	1,592
14										14
15		New Wing Construction	2010		20,853	1,218	10	2,085	867	3,128
16		-Drywall work, doors, furniture, equipment, change heating								16
17		and air conditioning, 10 new exit signs								17
18										18
19		Emcor Repair								19
20		-Replace blower motor, 2 compressors, 2 belts, flushed out	2010		10,153	423	10	1,015	592	1,690
21		2 condensor coils, new motor, 2 new capacitors, new								21
22		thermostat, new temp sensor, replace supply line, clean								22
23		exchanger tubes air filter & trap, clean evaporator coil,								23
24		recharge 2 units								24
25		-New boiler flow switch, rewired controls, boiler relief valve,	2010		3,349	140	10	335	195	335
26		adjust boiler damper motor location, 2 new couplers								26
27										27
28		New sprinkler system : repipe N & S hallways, heads for N, S & W	2010		15,647	391	10	1,565	1,174	2,347
29		hallways, bathrooms & nursing station, pressure test								29
30										30
31		Hot Water Replacement	2010		4,800		10	480	480	720
32										32
33		Provider Adjustment - Adj PY Depreciation				(606)			606	
34										34
35		Home Office Depreciation Allocation						3,594	3,594	
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Walnut Grove Village

0050468

Report Period Beginning:

01/01/11

Ending:

12/31/11

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 Doors Done Right-6 Doors- Invoice 4563 4/8/2011	2011	\$ 7,004	\$	15	\$ 233	\$ 233	\$ 233	37
38 RF Technologies-Wanderer System	2011	9,531		5	953	953	953	38
39 Illinois Electric Services Inv 113009336,113011336,113014336 Elec	2011	9,350		10	468	468	468	39
40 Illinois Electric Services - Install code alert model	2011	7,300		7	521	521	521	40
41 Menards - BTU Window AC & Stand fan	2011	3,119		10	156	156	156	41
42 Menards - BTU Window AC & ELEC DEHUM SOL	2011	3,638		10	182	182	182	42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61 To reconcile to financial statements			14,001			(14,001)		61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 114,521	\$ 18,849		\$ 14,871	\$ (3,978)	\$ 18,941	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 98,606	\$ 6,073	\$ 15,202	\$ 9,129		\$ 37,032	71
72	Current Year Purchases	47,364	2,607	2,730	123		2,730	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 145,970	\$ 8,680	\$ 17,932	\$ 9,252		\$ 39,762	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	N/A			\$ N/A	\$	\$	\$		\$ N/A
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

E. Summary of Care-Related Assets				1	2
		Reference			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)			\$ 260,491
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$ 27,529
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$ 32,803
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$ 5,274
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$ 58,703

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	N/A	\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92	N/A	\$
93		
94		
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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Wakefield Communities-Morris LLC
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:		123	08/01/09	\$ 819,996			3
4	Additions							4
5								5
6								6
7	TOTAL		123		\$ 819,996			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
- N/A

9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms:
- *

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

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☐ NO
16. Rental Amount for movable equipment: \$ 48,548
- Description: Various equipment rental & Home Office rent expense allocation (\$11,638) - See Sch 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

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.	/2012	\$
13.	/2013	\$
14.	/2014	\$

* 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.

Walnut Grove Village
Provider # 0050468
FYE: 12/31/11

Sch 14A

Summary of Equipment Rental:

<u>Acct. #</u>	<u>Account Description</u>	<u>Balance</u>
710620	Equipment Rental - Maintenance	15,985
911620	Equipment Rental - Nursing	17,417
912620	Equipment Rental - Dietary	413
912775	Equipment Rental - Dietary	1,238
925620	Equipment Rental - Other	849
930190	Other Rent/Lease Expense	<u>1,008</u>
	Subtotal	36,910
	Allocation from Management Company	11,638
	Total	<u><u>48,548</u></u>

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

☒ NO

It is the policy of this facility to only hire certified nurses aides.
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.

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

12345678										
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(2) &(3)	hrs	\$	3,714	\$ 303,276	\$	3,714	\$ 303,276	1
2	Licensed Speech and Language Development Therapist	10A(2) &(3)	hrs		676	86,123		676	86,123	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2) &(3)	hrs		4,541	379,867	619	4,541	380,486	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				283,797		283,797	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Respiratory therapy</u>	10A(1)	163	5,733				163	5,733	12
13	Other (specify): _____									13
14	TOTAL			\$ 5,733	8,931	\$ 769,266	\$ 284,416	9,094	\$ 1,059,415	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.

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	\$ 62,875	\$ 62,875	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 361,923)	1,226,520	1,226,520	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	17,790	17,790	7
8	Accounts Receivable (owners or related parties)	1,063,828	1,063,828	8
9	Other(specify): Other Rec - See Sch 17A	393,352	393,352	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,764,365	\$ 2,764,365	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	79,129	114,521	15
16	Equipment, at Historical Cost	162,505	145,970	16
17	Accumulated Depreciation (book methods)	(51,411)	(58,703)	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)	\$ 190,223	\$ 201,788	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,954,588	\$ 2,966,153	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,235,459	\$ 1,235,459	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	26,959	26,959	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	463,394	463,394	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	217,852	217,852	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Wakefield	10,000	10,000	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,953,664	\$ 1,953,664	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	Lease Payable	858,240	858,240	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 858,240	\$ 858,240	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,811,904	\$ 2,811,904	46
47	TOTAL EQUITY(page 18, line 24)	\$ 142,684	\$ 154,249	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,954,588	\$ 2,966,153	48

*(See instructions.)

Walnut Grove Village

Sch 17A

Provider # 0050468

FYE: 12/31/11

Detail of Other Receivables - Line #9:

<u>Acct. #</u>	<u>Account Description</u>	<u>Operating</u>	After <u>Consolidation</u>
153000	Real Estate Tax Escrow	140,662	140,662
153500	Capital Improvement Escrow	132,348	132,348
161000	Resident Trust Cash	26,959	26,959
261000	Deposits - Utilities	35,680	35,680
313100	W/H-Group Insurance	57,703	57,703
	Totals	393,352	393,352

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (189,228)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (189,228)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	331,913	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) Rounding	(1)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 331,912	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)	\$ 142,684	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,574,308	1
2	Discounts and Allowances for all Levels	(882,786)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,691,522	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,639,994	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,639,994	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	587,640	17
18	Sale of Supplies to Non-Patients	6,008	18
19	Laboratory	27,254	19
20	Radiology and X-Ray	21,087	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 641,989	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	314	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 314	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Other Revenue - See Sch 19A	12,145	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 12,145	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,985,964	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,104,707	31
32	Health Care	3,571,771	32
33	General Administration	1,387,471	33
	B. Capital Expense		
34	Ownership	1,017,585	34
	C. Ancillary Expense		
35	Special Cost Centers	503,973	35
36	Provider Participation Fee	68,544	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,654,051	40
41	Income before Income Taxes (line 30 minus line 40)**	331,913	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 331,913	43

* 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.

Walnut Grove Village

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Sch 19A

Summary of Other Revenue:

<u>Acct. #</u>	<u>Account Description</u>	<u>Balance</u>
613300	Transportation - Private	3,855
690050	Vending Machine Revenue	1,043
690900	Other Revenue	7,247
	Total Other Revenue	<u>12,145</u>

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,071	2,071	\$ 62,295	\$ 30.09	1
2	Assistant Director of Nursing	2,105	2,105	69,234	32.89	2
3	Registered Nurses	21,927	21,927	562,460	25.65	3
4	Licensed Practical Nurses	24,276	24,276	558,574	23.01	4
5	CNAs & Orderlies	92,508	92,508	1,049,745	11.35	5
6	CNA Trainees					6
7	Licensed Therapist	163	163	5,733	35.17	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,554	6,554	77,780	11.87	10
11	Social Service Workers	2,411	2,411	52,780	21.89	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,944	20,944	206,729	9.87	15
16	Dishwashers					16
17	Maintenance Workers	4,795	4,795	65,701	13.70	17
18	Housekeepers	17,270	17,270	190,209	11.01	18
19	Laundry	6,271	6,271	59,740	9.53	19
20	Administrator	2,088	2,088	80,649	38.63	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,536	7,536	127,475	16.92	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	2,101	2,101	30,928	14.72	31
32	Other Health C: Care plan Coordin	3,399	3,399	94,209	27.72	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	216,418	216,418	\$ 3,294,241 *	\$ 15.22	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	241	\$ 11,075	1(3)	35
36	Medical Director	Monthly	18,000	9(3)	36
37	Medical Records Consultant	Flat Rate	1,768	10(3)	37
38	Nurse Consultant	59	11,630	10(3)	38
39	Pharmacist Consultant	Flat Rate	9,008	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	16	720	11(3)	44
45	Social Service Consultant	14	397	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	330	\$ 52,598		49

C. CONTRACT NURSES

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

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount	
Carolyn Progress	Administrator	0	\$ 80,649	Workers' Compensation Insurance		\$ 111,624	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance		71,401	Advertising: Employee Recruitment		
				FICA Taxes		252,009	Health Care Worker Background Check		
				Employee Health Insurance		57,490	(Indicate # of checks performed 103)	1,640	
				Employee Meals		9,508	Patient Background Checks 103	1,640	
				Illinois Municipal Retirement Fund (IMRF)*			Miscellaneous Licenses	1,352	
				Other Employee Benefits		7,777	Miscellaneous Dues	686	
TOTAL (agree to Schedule V, line 17, col. 1)							Management company allocation	3,844	
(List each licensed administrator separately.)			\$ 80,649						
B. Administrative - Other							Less: Public Relations Expense ()		
Description			Amount				Non-allowable advertising ()		
Management Fees - Eliminated in Col #7			\$ 399,298				Yellow page advertising ()		
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 399,298	TOTAL (agree to Schedule V, line 22, col.8)			\$ 509,809		
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			TOTAL (agree to Sch. V, line 20, col. 8) \$ 11,152		
C. Professional Services							G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
See PG21A	See PG21A		\$ 61,899				Out-of-State Travel	\$	
				N/A					
							In-State Travel		
							Seminar Expense	2,411	
							(see attached schedule)		
							Management company allocation	1,492	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V, line 24, col. 8)		
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 61,899				TOTAL \$ 3,903		

*** Attach copy of IMRF notifications**

****See instructions.**

Walnut Grove Village

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PG 21 Detail - Professional Services

	<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
	Brian LaLonde, CPA	Accounting	1,100
	McGladrey & Pullen LLP	Accounting	5,189
	WW Health Care Consultants LLC	Legal	1,764
	Purcell & Wardrope	Legal	3,928
	Kavanagh Grumley & Gorbold, LL	Legal	2,226
	Williams Mullen	Legal	4,868
	Malmquist & Geiger	Legal/Collections	1,309
	O'Hagan Spencer, LLC	Legal	1,703
....	MDI Achieve	Data Processing	8,499
	WW Health Care Consultants LLC	Data Processing	246
	COMS Interactive, LLC	Data Processing	15,000
	McGladrey & Pullen LLP	Bookkeeping	950
	ADP, Inc	Payroll Processing	15,118
	Line #19 Column 3 Total		61,899
	Less: Nonallowable Legal Fees		(1,309)
	Plus: Allocated from Management Company	Accounting	10,524
	Line #19 Column 8 Total		71,114

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?

No

If YES, give association name and amount.

N/A

(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?

10-20 yrs

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$26,068

Line10

(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?

YESXNO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YESNOX

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.

\$68,544

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?

No

If YES, attach an explanation of the allocation.

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

Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

No

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

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

\$9,508

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?

N/A

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?

N/A

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

N/A

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) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?

Yes

Attach invoices and a summary of services for all architect and appraisal fees.