

		FOR BHF USE					

LL1

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: 15784

Facility Name: Walnut Manor, Inc.

Address: 308 South Second St. Walnut
Number City Zip Code

County: Bureau

Telephone Number: (815)379-2131 Fax # ()

HFS ID Number:

Date of Initial License for Current Owners: 1977

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: Craig Ater Telephone Number: (309) 823-7135
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 10/01/10 to 9/30/11 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)
	(Type or Print Name) Dennis Grobe (Date)
	(Title)
Paid Preparer	(Signed)
	(Date)
	(Print Name and Title) Craig Ater Exec VP & CFO
	(Firm Name & Address) Heritage Operations Group, LLC
	(Telephone) (309) 823-7135 Fax # ()

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

Facility Name & ID Number Walnut Manor, Inc.

15784 Report Period Beginning: 10/01/10 Ending: 9/30/11

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

	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	62	Skilled (SNF)	62	22,630	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	62	TOTALS	62	22,630	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	9,591	7,422	2,056	19,069	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,591	7,422	2,056	19,069	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.26%

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) none

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

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

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 1977

J. Was the facility purchased or leased after January 1, 1978? YES NO x

K. Was the facility certified for Medicare during the reporting year? YES x NO If YES, enter number of beds certified and days of care provided 2,056

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL x MODIFIED CASH* CASH*

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

Tax Year: Fiscal Year: * All facilities other than governmental must report on the accrual basis.

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	174,866	13,286		188,152		188,152		188,152			1
2	Food Purchase		156,861		156,861		156,861		156,861			2
3	Housekeeping	65,076	16,068		81,144		81,144		81,144			3
4	Laundry	53,069	9,545		62,614		62,614		62,614			4
5	Heat and Other Utilities			63,072	63,072		63,072		63,072			5
6	Maintenance	36,222	60,099	30,517	126,838		126,838		126,838			6
7	Other (specify):*											7
8	TOTAL General Services	329,233	255,859	93,589	678,681		678,681		678,681			8
	B. Health Care and Programs											
9	Medical Director			3,000	3,000		3,000		3,000			9
10	Nursing and Medical Records	892,788	73,808	2,628	969,224		969,224		969,224			10
10a	Therapy		46,498	269,144	315,642	(57,149)	258,493		258,493			10a
11	Activities	54,798	21,792		76,590		76,590		76,590			11
12	Social Services	29,418		2,970	32,388		32,388		32,388			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	977,004	142,098	277,742	1,396,844	(57,149)	1,339,695		1,339,695			16
	C. General Administration											
17	Administrative	69,694			69,694		69,694		69,694			17
18	Directors Fees			4,080	4,080		4,080		4,080			18
19	Professional Services			115,888	115,888		115,888	(2,382)	113,506			19
20	Dues, Fees, Subscriptions & Promotions			71,243	71,243	(33,945)	37,298	(27,199)	10,099			20
21	Clerical & General Office Expenses	91,039	24,557	4,588	120,184		120,184		120,184			21
22	Employee Benefits & Payroll Taxes			364,382	364,382		364,382		364,382			22
23	Inservice Training & Education			1,683	1,683		1,683		1,683			23
24	Travel and Seminar			2,821	2,821		2,821	(822)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			56,016	56,016		56,016		56,016			26
27	Other (specify):*			12,917	12,917		12,917	(12,917)				27
28	TOTAL General Administration	160,733	24,557	633,618	818,908	(33,945)	784,963	(43,320)	741,643			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,466,970	422,514	1,004,949	2,894,433	(91,094)	2,803,339	(43,320)	2,760,019			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			65,459	65,459		65,459		65,459			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,832	6,832		6,832	(2,666)	4,166			32
33	Real Estate Taxes			13,176	13,176		13,176	21,110	34,286			33
34	Rent-Facility & Grounds			480	480		480		480			34
35	Rent-Equipment & Vehicles			1,271	1,271		1,271		1,271			35
36	Other (specify):*											36
37	TOTAL Ownership			87,218	87,218		87,218	18,444	105,662			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					57,149	57,149		57,149			39
40	Barber and Beauty Shops		410	13,493	13,903		13,903		13,903			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					33,945	33,945		33,945			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		410	13,493	13,903	91,094	104,997		104,997			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,466,970	422,924	1,105,660	2,995,554		2,995,554	(24,876)	2,970,678			45

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

	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		35		5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(2,666)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions	21,110	33		15
16	Personal Expenses (Including Transportation)		23		16
17	Non-Care Related Fees	(756)	20		17
18	Fines and Penalties				18
19	Entertainment	(822)	24		19
20	Contributions		27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,382)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,917)	27		24
25	Fund Raising, Advertising and Promotional	(26,443)	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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$(24,876)		\$	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
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$(24,876)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Walnut Manor, Inc.

ID# 15784

Report Period Beginning: 10/01/10

Ending: 9/30/11

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5		0	35 5
6		0	34 6
7			7
8			8
9		0	30 9
10			32 10
11			11
12			12
13		0	2 13
14			32 14
15		0	33 15
16			24 16
17		(756)	20 17
18			18
19			24 19
20		0	27 20
21			21
22		(2,382)	19 22
23			23
24		(12,917)	27 24
25		(26,443)	20 25
26			26
27			27
28			28
29			33 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	(42,498)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Walnut Manor, Inc. # 15784 Report Period Beginning: 10/01/10 Ending: 9/30/11

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,382)	0	0	0	0	0	0	0	0	0	0	(2,382)	19
20	Fees, Subscriptions & Promotions	(27,199)	0	0	0	0	0	0	0	0	0	0	(27,199)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(822)	0	0	0	0	0	0	0	0	0	0	(822)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(12,917)	0	0	0	0	0	0	0	0	0	0	(12,917)	27
28	TOTAL General Administration	(43,320)	0	0	0	0	0	0	0	0	0	0	(43,320)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(43,320)	0	0	0	0	0	0	0	0	0	0	(43,320)	29

STATE OF ILLINOIS

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,666)	0	0	0	0	0	0	0	0	0	0	(2,666)	32
33	Real Estate Taxes	21,110	0	0	0	0	0	0	0	0	0	0	21,110	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	18,444	0	0	0	0	0	0	0	0	0	0	18,444	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(24,876)	0	0	0	0	0	0	0	0	0	0	(24,876)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

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

☐ YES

☐ NO

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

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

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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	attached								\$		1
2											2
3	Board Fees								4,080	line 18	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 4,080		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

#	15784	Report Period Beginning:	10/01/10	Ending:	9/30/11
---	-------	--------------------------	----------	---------	---------

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										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

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	Citizens First State		xx	Working Capital				104,230				6,832	6
7													7
8													8
9	TOTAL Facility Related						\$	104,230				\$ 6,832	9
	B. Non-Facility Related*												
10	Interest Income											(2,666)	10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$					\$ (2,666)	14
15	TOTALS (line 9+line14)						\$	104,230				\$ 4,166	15

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

* 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

	Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.										
1.	Real Estate Tax accrual used on 2010 report.							\$		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.)							\$		2	
3.	Under or (over) accrual (line 2 minus line 1).							\$	34,286	3	
4.	Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)							\$		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.							\$	34,286	7	
Real Estate Tax History:											
Real Estate Tax Bill for Calendar Year:		2006		29,691	8						
		2007		35,214	9						
		2008		39,601	10						
		2009		40,196	11						
		2010		34,286	12						
							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	<u>Walnut Manor, Inc.</u>	COUNTY	<u>Bureau</u>
FACILITY IDPH LICENSE NUMBER	<u>15784</u>		
CONTACT PERSON REGARDING THIS REPORT	<u></u>		
TELEPHONE ()	<u></u>	FAX #: ()	<u></u>

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 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:	18,000	B. General Construction Type:	Exterior	brick	Frame	wood	Number of Stories	1
------------------------	---------------	--------------------------------------	-----------------	--------------	--------------	-------------	--------------------------	----------

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

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

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

none

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
If so, please complete the following:

1. Total Amount Incurred:	2. Number of Years Over Which it is Being Amortized:
----------------------------------	---

3. Current Period Amortization: **4. Dates Incurred:**

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				\$ 20,610	1
2					2
3	TOTALS			\$ 20,610	3

XI. OWNERSHIP COSTS (continued)										
B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.										
	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	62				\$ 469,470	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Improvements		1977		1,605					9
10	Improvements		1979		15					10
11	Improvements		1978		3,737					11
12	Improvements		1980		12,962					12
13	Improvements		1981		6,721					13
14	Improvements		1982		2,572					14
15	Improvements		1983		1,394					15
16	Improvements		1984		10,068					16
17	Improvements		1985		2,599					17
18	Improvements		1988		6,911					18
19	Improvements		1991		15,262					19
20	Improvements		1992		28,595					20
21	Improvements		1993		8,420					21
22	Improvements		1994		12,336					22
23	Improvements		1995		14,430					23
24	Chair rail		1996		6,870					24
25	Tile		1996		1,131					25
26	Door Frames		1996		2,345					26
27	Cabinets		1998		4,228					27
28	Bathroom Remodeling		1999		8,243					28
29	Med Room Improvements		1999		4,922					29
30	Wander Guard System		2000		760					30
31	Fire Alarm		2000		675					31
32	Main Entrance Alarm		2000		2,422					32
33	Drapes		2001		1,126					33
34	Fire Doors		2001		2,255				(35,677)	34
35	Book Depreciation					35,677		35,677	#REF!	35
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

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 Living Room Railing	2001	\$ 444	\$		\$	\$	\$	37
38 Drapes	2001	967						38
39								39
40 Improvements	1973	22,000						40
41 Improvements	1976	1,055						41
42 Improvements	1978	73						42
43 Improvements	1980	48						43
44 Improvements	1982	1,616						44
45 Improvements	1983	1,330						45
46 Improvements	1984	213						46
47 Improvements	1985	11,880						47
48 Improvements	1988	400						48
49 Improvements	1995	8,735						49
50								50
51 Retention Pond	1997	7,565						51
52								52
53 Improvements	1978	53,783						53
54 Improvements	1979	1,207						54
55 Improvements	1982	105						55
56 Improvements	1984	310						56
57 Improvements	1985	1,107						57
58 Improvements	1986	570						58
59 Improvements	1987	1,811						59
60 Improvements	1988	575						60
61 Improvements	1989	3,412						61
62 Improvements	1990	10,184						62
63 Improvements	1991	3,193						63
64 Improvements	1994	11,944						64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 776,601	\$ 35,677		\$ 35,677	\$ #REF!	\$	70

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

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	
1 Totals from Page 12A, Carried Forward		\$ 776,601	\$ 35,677		\$ 35,677	\$	\$	1
2								2
3 Cabinets	1998	3,647						3
4 Bathroom Fixtures	1999	18,379						4
5 Doors	1999	4,900						5
6 Furnace	2001	1,527						6
7 Air Conditioner	2001	1,435						7
8								8
9 Smoke Detector	2002	2,754						9
10 Emergency Lights	2002	1,188						10
11 Fire Dampers	2002	6,455						11
12 Insulated Door	2002	635						12
13								13
14 Heating Ducts	2003	6,455						14
15 Shower Stall	2003	1,410						15
16 Rooftop A/C	2003	7,550						16
17								17
18 Door Monitor	2004	3,528						18
19 3 Keyless Door Locks	2004	1,086						19
20								20
21 Boiler	2005	3,725						21
22 Water Heater	2005	4,700						22
23 Door Frames	2005	1,217						23
24 Fire Ext	2005	1,632						24
25 A/C Condenser	2005	1,850						25
26 MedCare Stand	2005	1,217						26
27								27
28 Foundation repair	2006	2,992						28
29 Valve -- Water Heater	2006	587						29
30 Service sink	2006	912						30
31 Building wiring	2006	6,659						31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 863,041	\$ 35,677		\$ 35,677	\$	\$	34

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

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	
1 Totals from Page 12B, Carried Forward		\$ 863,041	\$ 35,677		\$ 35,677	\$	\$	1
2								2
3 Furnace	2007	2,851						3
4 HVAC Air handler	2007	7,400						4
5 Downflow a/c coil	2007	3,555						5
6 2 Hanging furnaces	2007	7,458						6
7 Window	2007	1,512						7
8								8
9 Compressor	2008	1,338						9
10 Corridor painting	2008	1,700						10
11 Parking Lot Seal	2008	7,850						11
12 A/C condensor	2008	6,886						12
13 Smoke Damper	2008	2,455						13
14 Laundry Room A/C	2008	6,088						14
15								15
16 Corridor Renovation: Paint, lighting, flooring & Décor	2009	48,271						16
17 Therapy Room Renovation: Paint & Décor	2009	4,100						17
18 Wanderguard	2009	3,250						18
19 West Wing Air Handler	2009	6,265						19
20 Patio Renovation: Concrete	2009	4,219						20
21 Garage Siding	2009	3,634						21
22 Roof	2009	21,328						22
23								23
24 Phone system	2010	3,118						24
25 Sidewalk	2010	3,188						25
26 Fence	2010	3,900						26
27 Tile & Plumbing Kitchen	2010	24,051						27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 1,037,458	\$ 35,677		\$ 35,677	\$	\$	34

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

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	
1 Totals from Page 12C, Carried Forward		\$ 1,037,458	\$ 35,677		\$ 35,677	\$	\$	1
2								2
3 Sprinkler System	2011	90,602						3
4 Ceramic Tile	2011	5,868						4
5 Water Heater	2011	7,595						5
6 Fire Alarm	2011	6,875						6
7 A/C for Therapy Room	2011	7,456						7
8 Aquaclean extractor	2011	3,175						8
9 Asphalt Sealer	2011	7,000						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 TOTAL (lines 1 thru 33)		\$ 1,166,029	\$ 35,677		\$ 35,677	\$	\$	34

**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	\$371,818	\$29,782	\$29,782	\$		\$	71
72	Current Year Purchases	9,961						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$381,779	\$29,782	\$29,782	\$		\$	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		2008 van	2008	\$58,504	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$58,504	\$	\$	\$		\$	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)	\$1,626,922	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$65,459	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$65,459	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
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: *

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

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$1,271 Description:
- ☐ YES☐ NO
- (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

10. Effective dates of current rental agreement:
Beginning
Ending
11. Rent to be paid in future years under the current rental agreement:

Fiscal Year EndingAnnual 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.

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

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

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

In the box below record the amount of income your facility received training CNAs from other facilities.

		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)	\$			

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.)

	1	2	3	4	5	6	7	8	
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		hrs	\$		\$ 135,316		\$ 135,316	1
2	Licensed Speech and Language Development Therapist		hrs			1,175		1,175	2
3	Licensed Recreational Therapist		hrs						3
4	Licensed Physical Therapist		hrs			121,148	854	122,002	4
5	Physician Care		visits						5
6	Dental Care		visits						6
7	Work Related Program		hrs						7
8	Habilitation		hrs						8
9	Pharmacy		# of prescrpts				45,644	45,644	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs						10
11	Academic Education		hrs						11
12	Other (specify):								12
13	Other (specify):					11,505		11,505	13
14	TOTAL			\$		\$ 269,144	\$ 46,498	\$ 315,642	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.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (61,904)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	429,393		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	23,088		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	200,902		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 591,479	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,610		13
14	Buildings, at Historical Cost	1,603,918		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	628,998		16
17	Accumulated Depreciation (book methods)	(1,528,370)		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)	\$ 725,156	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,316,635	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 70,988	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	23,304		30
31	Accrued Taxes Payable (excluding real estate taxes)	16,076		31
32	Accrued Real Estate Taxes(Sch.IX-B)	39,827		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)	\$ 150,195	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	104,230		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)	\$ 104,230	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 254,425	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,062,210	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,316,635	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$813,244	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$813,244	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	248,966	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)	\$248,966	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)	\$1,062,210	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.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,087,424	1
2	Discounts and Allowances for all Levels	(795,162)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,292,262	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	837,725	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 837,725	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	252	12
13	Barber and Beauty Care	15,544	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	90,441	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)	\$ 106,237	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,666	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,666	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28		5,630	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 5,630	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,244,520	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	678,681	31
32	Health Care	1,396,844	32
33	General Administration	818,908	33
	B. Capital Expense		
34	Ownership	87,218	34
	C. Ancillary Expense		
35	Special Cost Centers	13,903	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)*	\$ 2,995,554	40
41	Income before Income Taxes (line 30 minus line 40)**	248,966	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 248,966	43

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

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

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

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

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,900	2,080	\$ 64,160	\$ 30.85	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	4,733	5,210	130,034	24.96	3
4	Licensed Practical Nurses	13,115	14,657	263,998	18.01	4
5	CNAs & Orderlies	36,408	39,478	434,596	11.01	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides			0		8
9	Activity Director					9
10	Activity Assistants	3,640	4,030	54,798	13.60	10
11	Social Service Workers	1,676	1,826	29,418	16.11	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,150	17,882	174,866	9.78	15
16	Dishwashers					16
17	Maintenance Workers	3,277	3,466	36,222	10.45	17
18	Housekeepers	5,585	5,820	65,076	11.18	18
19	Laundry	6,440	8,148	53,069	6.51	19
20	Administrator	1,900	2,080	69,694	33.51	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,948	4,394	91,039	20.72	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)	97,772	109,071	\$ 1,466,970 *	\$ 13.45	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 0		35
36	Medical Director		3,000		36
37	Medical Records Consultant		0		37
38	Nurse Consultant				38
39	Pharmacist Consultant		1,571		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		2,970		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 7,541		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	0	\$ 0		50
51	Licensed Practical Nurses	0	0		51
52	Certified Nurse Assistants/Aides	0	0		52
53	TOTAL (lines 50 - 52)		\$		53

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
Dennis Grobe			\$ 69,694	Workers' Compensation Insurance		\$ 32,990	IDPH License Fee	\$ 0
				Unemployment Compensation Insurance		19,069	Advertising: Employee Recruitment	497
				FICA Taxes		112,223	Health Care Worker Background Check	
				Employee Health Insurance		188,729	(Indicate # of checks performed)	1,150
				Employee Meals			Patient Background Checks	
				Illinois Municipal Retirement Fund (IMRF)*				
						472		6,550
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 69,694	Other Benefits		10,899	Dues & Subscriptions	4,441
(List each licensed administrator separately.)				Central Office Allocation			License & Fees	4,767
B. Administrative - Other							Central Office Allocation	
Description			Amount				Less: Public Relations Expense	(6,550)
			\$				Non-allowable advertising	(756)
							Yellow page advertising (	)
				TOTAL (agree to Schedule V,		\$ 364,382	TOTAL (agree to Sch. V,	\$ 10,099
				line 22, col.8)			line 20, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	E. Schedule of Non-Cash Compensation Paid			G. Schedule of Travel and Seminar**	
(Attach a copy of any management service agreement)				to Owners or Employees			Description	Amount
C. Professional Services				Description	Line #	Amount		
Vendor/Payee	Type		Amount			\$	Out-of-State Travel	\$
Heritage Operations Group			\$ 108,001					
Principal Financial	401K		2,020					
Birkey & Co	Tax		2,790					
McQuellen	Tax Consult		695				In-State Travel	
								0
								75
							Seminar Expense	2,746
							Central Office	(822)
Legal adj to Zero			2,382				Entertainment Expense (	)
							(agree to Sch. V,	
TOTAL (agree to Schedule V, line 19, column 3)			\$ 115,888	TOTAL		\$	line 24, col. 8)	\$ 1,999
(If total legal fees exceed \$5,000, attach copy of invoices.)							TOTAL	

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type		Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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.

Illinois Health Care Association

(3) Did the nursing home make political contributions or payments to a political action organization?

yes

If YES, have these costs been properly adjusted out of the cost report?

yes

(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?

(5) Have you properly capitalized all major repairs and equipment purchases?

yes

What was the average life used for new equipment added during this period?

7 years

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

\$5,000

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.

(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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$33,945

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?

yes

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.

\$0

Has any meal income been offset against related costs?

yes

Indicate the amount.

\$7,158

(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.

\$

c. What percent of all travel expense relates to transportation of nurses and patients?

100%

d. Have vehicle usage logs been maintained?

yes

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

yes

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.

\$

(17) Has an audit been performed by an independent certified public accounting firm?

no

Firm Name:

(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.

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IL478-2471