

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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 60450
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: Amanda Springborn Telephone Number: (314) 925-3838
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 01/01/12 to 12/31/12 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) _____
(Title) _____

Paid
Preparer

(Signed) _____ (Date) _____
(Print Name and Title) _____
(Firm Name & Address) McGladrey LLP
20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

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 Grove Village

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

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	123	Skilled (SNF)	123	45,018	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	123	TOTALS	123	45,018	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	18,597	7,555	9,158	35,310	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,597	7,555	9,158	35,310	14

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

78.44%

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 7,284

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: 12/31/12 Fiscal Year: 12/31/12

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

	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	196,714	28,925	15,269	240,908		240,908		240,908			1
2	Food Purchase		203,019		203,019		203,019	(7,168)	195,851			2
3	Housekeeping	144,941	23,076	1,336	169,353		169,353		169,353			3
4	Laundry	51,356	9,908		61,264		61,264		61,264			4
5	Heat and Other Utilities			73,950	73,950		73,950	3,591	77,541			5
6	Maintenance	70,630	18,102	109,804	198,536		198,536	(1,271)	197,265			6
7	Other (specify):*											7
8	TOTAL General Services	463,641	283,030	200,359	947,030		947,030	(4,848)	942,182			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	2,364,871	174,487	21,406	2,560,764		2,560,764		2,560,764			10
10a	Therapy											10a
11	Activities	63,102	1,583	2,582	67,267		67,267		67,267			11
12	Social Services	32,648		2,573	35,221		35,221		35,221			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,460,621	176,070	44,561	2,681,252		2,681,252		2,681,252			16
	C. General Administration											
17	Administrative	70,982		396,255	467,237		467,237	(396,255)	70,982			17
18	Directors Fees											18
19	Professional Services			90,731	90,731		90,731	8,896	99,627			19
20	Dues, Fees, Subscriptions & Promotions			4,611	4,611		4,611	5,103	9,714			20
21	Clerical & General Office Expenses	149,453	39,780	43,351	232,584		232,584	232,235	464,819			21
22	Employee Benefits & Payroll Taxes			527,926	527,926		527,926	5,218	533,144			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,220	5,220		5,220	1,619	6,839			24
25	Other Admin. Staff Transportation			29,085	29,085		29,085	158	29,243			25
26	Insurance-Prop.Liab.Malpractice			100,957	100,957		100,957	2,895	103,852			26
27	Other (specify):* HO Alloc - Benefits							32,166	32,166			27
28	TOTAL General Administration	220,435	39,780	1,198,136	1,458,351		1,458,351	(107,965)	1,350,386			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,144,697	498,880	1,443,056	5,086,633		5,086,633	(112,813)	4,973,820			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			31,524	31,524		31,524	10,584	42,108			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							5,666	5,666			32
33	Real Estate Taxes			120,768	120,768		120,768		120,768			33
34	Rent-Facility & Grounds			625,217	625,217		625,217		625,217			34
35	Rent-Equipment & Vehicles			24,745	24,745		24,745	6,270	31,015			35
36	Other (specify):*											36
37	TOTAL Ownership			802,254	802,254		802,254	22,520	824,774			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	11,956	376,268	841,379	1,229,603		1,229,603		1,229,603			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			247,978	247,978		247,978		247,978			42
43	Other (specify):* Non-Allowable Co			66,633	66,633		66,633	(66,633)				43
44	TOTAL Special Cost Centers	11,956	376,268	1,155,990	1,544,214		1,544,214	(66,633)	1,477,581			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,156,653	875,148	3,401,300	7,433,101		7,433,101	(156,926)	7,276,175			45

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(6,255)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	7,718	30		9
10	Interest and Other Investment Income	(997)	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	(7,542)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(10,046)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(12,382)	43		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	(51,658)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (81,162)		\$	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)	(75,764)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (75,764)		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (156,926)		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:		01/01/12
Ending:		12/31/12

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Radiology	\$ (18,361)	43	1
2	Laboratory	(22,093)	43	2
3	Vending Machine Revenue offset	(1,950)	2	3
4	Capitalize Repairs Expenses	(2,762)	6	4
5	Non allowable chamber dues	(700)	20	5
6	Other Revenue offset	(5,792)	21	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(51,658)		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	Regency Care of Mountain Ridge	North Carolina	Coventry Cottages	Sterling, IL	Independent Liv.
		Regency Care of Clemmons	North Carolina	Walnut Grove Cottage	Morris	Independent Liv.
		Regency Care of Mount Sterling	Kentucky	N100LW, LLC	Hickory, NC	Airplane entity
		Regency Care of Blountstown	Florida	DMG Aero , LLC	Hickory, NC	Airplane entity
		Coventry Living Center	Sterling, IL	Regency Care Holding	Hickory, NC	Holding Co.
				SCK Assurance, LLC	Hickory, NC	Insurance Co.

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	5	Utilities	\$	WW Healthcare Consultants, LLC		\$ 3,591	\$ 3,591	1
2	V	6	Maintenance & Repair - Other		WW Healthcare Consultants, LLC		1,491	1,491	2
3	V	17	Management Fees	396,255	WW Healthcare Consultants, LLC			(396,255)	3
4	V	19	Professional Services		WW Healthcare Consultants, LLC		18,942	18,942	4
5	V	20	Dues, Fees, Subs. & Promotions		WW Healthcare Consultants, LLC		2,668	2,668	5
6	V	21	Clerical/General-Other		WW Healthcare Consultants, LLC		21,883	21,883	6
7	V	21	Office/Other Supplies		WW Healthcare Consultants, LLC		299	299	7
8	V	21	Salaries/Wages		WW Healthcare Consultants, LLC		218,880	218,880	8
9	V	24	Travel/Seminar		WW Healthcare Consultants, LLC		1,877	1,877	9
10	V	26	Insurance		WW Healthcare Consultants, LLC		2,895	2,895	10
11	V	27	Employee Benefits		WW Healthcare Consultants, LLC		32,166	32,166	11
12	V	30	Depreciation		WW Healthcare Consultants, LLC		2,866	2,866	12
13	V	32	Interest		WW Healthcare Consultants, LLC		6,663	6,663	13
14	Total			\$ 396,255			\$ 314,221	\$ * (82,034)	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	35	Rent	\$	WW Healthcare Consultants, LLC		\$ 6,270	\$ 6,270	15
16	V								16
17	V								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			\$			\$ 6,270	\$ * 6,270	39

* 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	26	Insurance	\$ 81,939	SCK assurance, LLC		\$ 81,939	\$	15
16	V								16
17	V								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			\$ 81,939			\$ 81,939	\$ *	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 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									\$		1
2											2
3											3
4											4
5			Note : No owners received compensation from this facility.								5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		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

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	NRF Healthcare, LLC		X	Rent Arrearages	Demand	7/1/11		312,078	312,078	Demand	-0-		6	
7													7	
8													8	
9	TOTAL Facility Related						\$	312,078	\$	312,078			9	
	B. Non-Facility Related*													
10													10	
11													11	
12							HO Interest Allocation					6,663	12	
13							Interest Income Offset					(997)	13	
14	TOTAL Non-Facility Related						\$		\$			\$	5,666	14
15	TOTALS (line 9+line14)						\$	312,078	\$	312,078		\$	5,666	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

		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 2011 report.			\$	217,852	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.)		2011	\$		2
3. Under or (over) accrual (line 2 minus line 1).			\$	(217,852)	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	425,413	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
		Cottage RE Tax - Non-Allowable		(86,793)	
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.			\$	120,768	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007		8	
		2008		9	
		2009	122,435	10	
		2010	121,856	11	
		2011	90,178	12	
Accrual Calculation: PY Accrual: \$217,852					
+ CY RE Tax Expense: \$120,768					
+ Cottage Accrual: \$86,793					
Total: \$425,413					
		FOR BHF USE ONLY			
		13	FROM R. E. TAX STATEMENT FOR 2011	\$	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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Walnut Grove Village COUNTY Grundy

FACILITY IDPH LICENSE NUMBER 0050468

CONTACT PERSON REGARDING THIS REPORT Gene Woodard

TELEPHONE (828) 381-4923 FAX #: Please call, faxes may not be received.

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

(A)		(B)	(C)	(D)
Tax Index Number		Property Description	Total Tax	Tax Applicable to Nursing Home
1.	02-33-301-013	Nursing Facility	\$ 89,132.62	\$ 89,132.62
2.	02-33-301-006	Nursing Facility	\$ 604.66	\$ 604.66
3.	02-33-353-025	Nursing Facility	\$ 179.78	\$ 179.78
4.	02-33-353-026	Nursing Facility	\$ 260.54	\$ 260.54
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
TOTALS			\$ 90,177.60	\$ 90,177.60

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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 BrickFrame WoodNumber 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	Focus Fire		2009		6,096	1,219	5	1,219		4,267
10	Flooring		2009		3,774	755	5	755		2,642
11	Landscaping-Lava Rock		2009		6,723	672	10	672		2,352
12	Carpet		2009		3,183	637	5	637	0	2,229
13										13
14	New Wing Construction		2010		20,853	2,085	10	2,085	0	5,213
15	-Drywall work, doors, furniture, equipment, change heating									15
16	and air conditioning, 10 new exit signs									16
17										17
18	Emcor Repair									18
19	-Replace blower motor, 2 compressors, 2 belts, flushed out		2010		10,153	1,015	10	1,015	0	2,705
20	2 condensor coils, new motor, 2 new capacitors, new									20
21	thermostat, new temp sensor, replace supply line, clean									21
22	exchanger tubes air filter & trap, clean evaporator coil,									22
23	recharge 2 units									23
24	-New boiler flow switch, rewired controls, boiler relief valve,		2010		3,349	335	10	335	(0)	670
25	adjust boiler damper motor location, 2 new couplers									25
26										26
27	New sprinkler system : repipe N & S hallways, heads for N, S & W		2010		15,647	1,565	10	1,565	(0)	3,912
28	hallways, bathrooms & nursing station, pressure test									28
29										29
30	Hot Water Replacement		2010		4,800		10	480	480	1,200
31										31
32										32
33										33
34										34
35										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	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Doors Done Right-6 Doors- Invoice 4563 4/8/2011	2011	\$ 7,004	\$	15	\$ 467	\$ 467	\$ 700	37
38	RF Technologies-Wanderer System	2011	9,531		5	1,906	1,906	2,859	38
39	Illinois Electric Services Inv 113009336,113011336,113014336 Elec	2011	9,350	936	10	935	(1)	1,403	39
40	Illinois Electric Services - Install code alert model	2011	7,300		7	1,043	1,043	1,564	40
41	Menards - BTU Window AC & Stand fan	2011	3,119		10	312	312	468	41
42	Menards - BTU Window AC & ELEC DEHUM SOL	2011	3,638		10	364	364	546	42
43									43
44	Sprinkler System - Nursing Home	2012	10,326	794	10	516	(278)	516	44
45	New Door Installation - Employee Entrance & Service Hall	2012	6,330	29	10	317	288	317	45
46	R/M Reclass: Chiller Condenser (outside, service entrance)	2012	2,762		5	276	276	276	46
47	Equipment Reclass: Generator (outside, off large dining rm.)	2012	4,617		5	462	462	462	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									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 138,555	\$ 10,041		\$ 15,361	\$ 5,319	\$ 34,301	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	\$132,767	\$18,706	\$20,662	\$1,956	2-20	\$47,222	71
72	Current Year Purchases	39,691	2,777	3,219	442	3-10	3,219	72
73	Fully Depreciated Assets	13,203					13,203	73
74	Management Company Allocation			2,866	2,866			74
75	TOTALS	\$185,661	\$21,483	\$26,747	\$5,264		\$63,644	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			\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

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)	\$324,216	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$31,524	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$42,108	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$10,583	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$97,945	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	\$4,400	92
93			93
94			94
95		\$4,400	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	1/1/10	\$ 625,217	15		3
4	Additions							4
5								5
6								6
7	TOTAL		123		\$ 625,217			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: \$ 31,015Description: Various equipment rental & Home Office rent expense allocation (\$6,270) - 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:

Beginning3/26/10

Ending3/31/2025

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	December 31, 2013	\$ 648,000
13.	December 31, 2014	\$ 702,000
14.	December 31, 2015	\$ 702,000

* 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: 12/31/12

Sch 14A

Summary of Equipment Rental:

<u>Acct. #</u>	<u>Account Description</u>	<u>Balance</u>
710620	Equipment Rental - Maintenance	3,472
911620	Equipment Rental - Nursing	16,076
912620	Equipment Rental - Dietary	1,271
912775	Equipment Rental - Dietary	143
930190	Other Rent/Lease Expense	<u>3,783</u>
	Subtotal	24,745
	Allocation from Management Company	6,270
	Total	<u><u>31,015</u></u>

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

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.)

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	39(2) &(3)	hrs	\$	7,035	\$ 400,689	\$ 4	7,035	\$ 400,693	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,515	84,326		1,515	84,326	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(2) &(3)	hrs		6,148	355,588	528	6,148	356,116	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				375,616		375,616	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Respiratory Therapy	39(1) & (2)	564	11,956			120	564	12,076	12
13	Other (specify):									13
14	TOTAL			\$ 11,956	14,698	\$ 840,603	\$ 376,268	15,262	\$ 1,228,827	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	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 215,799	\$ 215,799	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 207,394)	1,698,107	1,698,107	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	36,433	36,433	7
8	Accounts Receivable (owners or related parties)	1,516,623	1,516,623	8
9	Other(specify): Other Rec - See Sch 17A	657,593	657,593	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,124,555	\$ 4,124,555	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	95,785	138,555	15
16	Equipment, at Historical Cost	206,813	185,661	16
17	Accumulated Depreciation (book methods)	(82,936)	(97,945)	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 (spec CIP	4,400	4,400	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 224,062	\$ 230,671	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,348,617	\$ 4,355,226	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,045,312	\$ 1,045,312	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	28,739	28,739	28
29	Short-Term Notes Payable	312,078	312,078	29
30	Accrued Salaries Payable	443,238	443,238	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	425,413	425,413	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Sch. 17A	88,831	88,831	36
37	See Sch. 17A	207,697	207,697	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,551,308	\$ 2,551,308	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,551,308	\$ 2,551,308	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,797,309	\$ 1,803,918	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,348,617	\$ 4,355,226	48

*(See instructions.)

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

Sch 17A

Detail of Other Receivables - Line #9:

<u>Acct. #</u>	<u>Account Description</u>	<u>After</u>	
		<u>Operating</u>	<u>Consolidation</u>
153000	Real Estate Tax Escrow	352,374	352,374
153500	Capital Improvement Escrow	187,428	187,428
161000	Resident Trust Cash	28,739	28,739
261000	Deposits - Utilities	35,680	35,680
313100	W/H-Group Insurance	53,372	53,372
Totals		657,593	657,593

Detail of Other Current Liabilities - Line #36:

<u>Acct. #</u>	<u>Account Description</u>	<u>After</u>	
		<u>Operating</u>	<u>Consolidation</u>
151200	Prepaid Workers Comp	34,163	34,163
319800	W/H Employee Advances	(349)	(349)
337000	Due to Medicaid/Medicare Audit	55,017	55,017
Totals		88,831	88,831

Detail of Other Current Liabilities - Line #37:

<u>Acct. #</u>	<u>Account Description</u>	<u>After</u>	
		<u>Operating</u>	<u>Consolidation</u>
133107	Due to/from WWHCC	9,697	9,697
133170	Due to/from RCMS	198,000	198,000
Totals		207,697	207,697

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 142,684	1
2	Restatements (describe):		2
3	Prior Period Adjustment (See Schedule 18A)	1,135,196	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,277,880	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	519,429	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)	\$ 519,429	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)	\$ 1,797,309	24 *

* This must agree with page 17, line 47.

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

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	2	
I. Revenue	Amount		
A. Inpatient Care			
1 Gross Revenue -- All Levels of Care	\$ 5,737,081	1	
2 Discounts and Allowances for all Levels	(2,062,823)	2	
3 SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,674,258	3	
B. Ancillary Revenue			
4 Day Care		4	
5 Other Care for Outpatients		5	
6 Therapy	3,393,940	6	
7 Oxygen		7	
8 SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,393,940	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	770,402	17	
18 Sale of Supplies to Non-Patients	1,830	18	
19 Laboratory	35,663	19	
20 Radiology and X-Ray	38,558	20	
21 Other Medical Services		21	
22 Laundry		22	
23 SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 846,453	23	
D. Non-Operating Revenue			
24 Contributions		24	
25 Interest and Other Investment Income***	997	25	
26 SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 997	26	
E. Other Revenue (specify):****			
27 Settlement Income (Insurance, Legal, Etc.)		27	
28		28	
28a <u>Other Revenue - See Sch 19A</u>	36,882	28a	
29 SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 36,882	29	
30 TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,952,530	30	

	1	2	
II. Expenses	Amount		
A. Operating Expenses			
31 General Services	947,030	31	
32 Health Care	2,681,252	32	
33 General Administration	1,458,351	33	
B. Capital Expense			
34 Ownership	802,254	34	
C. Ancillary Expense			
35 Special Cost Centers	1,296,236	35	
36 Provider Participation Fee	247,978	36	
D. Other Expenses (specify):			
37		37	
38		38	
39		39	
40 TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,433,101	40	
41 Income before Income Taxes (line 30 minus line 40)**	519,429	41	
42 Income Taxes		42	
43 NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 519,429	43	

III. Net Inpatient Revenue detailed by Payer Source			
44 Medicaid - Net Inpatient Revenue	\$ 2,336,975	44	
45 Private Pay - Net Inpatient Revenue	1,193,764	45	
46 Medicare - Net Inpatient Revenue	48,979	46	
47 Other-(specify) <u>Managed Care & Retro</u>	5,848	47	
48 Other-(specify) <u>See Sch 19A</u>	88,692	48	
49 TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,674,258	49	

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

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

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

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

Walnut Grove Village

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Sch 19A

Summary of Other Revenue:

Acct. #	Account Description	Balance
613300	Transportation - Private	1,715
690050	Vending Machine Revenue	1,950
690900	Other Revenue	5,792
950390	Other Bad Debts	27,425
Total Other Revenue		36,882

III. Net Inpatient Revenue detailed by Payer Source

Other-(specify) Other Payors	(73,808)
Other-(specify) Hospice	162,500
Subtotal	88,692

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	1,984	2,153	\$ 60,584	\$ 28.14	1
2	Assistant Director of Nursing	1,736	1,976	56,371	28.53	2
3	Registered Nurses	21,841	23,464	590,469	25.16	3
4	Licensed Practical Nurses	24,464	25,767	568,663	22.07	4
5	CNAs & Orderlies	84,831	89,988	1,003,003	11.15	5
6	CNA Trainees					6
7	Licensed Therapist	541	564	11,956	21.20	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,233	5,623	63,102	11.22	10
11	Social Service Workers	2,512	2,649	32,648	12.32	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,554	21,327	196,714	9.22	15
16	Dishwashers					16
17	Maintenance Workers	5,694	6,042	70,630	11.69	17
18	Housekeepers	15,326	16,894	144,941	8.58	18
19	Laundry	5,520	6,008	51,356	8.55	19
20	Administrator	1,976	2,080	70,982	34.13	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,134	8,813	149,453	16.96	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	1,967	2,098	28,785	13.72	31
32	Other Health Care MDS Coord.	1,656	1,926	56,996	29.59	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	202,969	217,372	\$ 3,156,653 *	\$ 14.52	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	287	\$ 15,269	1(3)	35
36	Medical Director	Monthly	18,000	9(3)	36
37	Medical Records Consultant	Flat Rate	1,784	10(3)	37
38	Nurse Consultant	58	7,478	10(3)	38
39	Pharmacist Consultant	Flat Rate	5,948	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Flat Rate	611	39(3)	42
43	Speech Therapy Consultant				43
44	Activity Consultant	17	1,160	11(3)	44
45	Social Service Consultant	58	2,573	12(3)	45
46	Other(specify) Dental Consultant	Flat Rate	165	39(3)	46
47					47
48					48
49	TOTAL (lines 35 - 48)	420	\$ 52,988		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	\$ 70,982	Workers' Compensation Insurance		\$ 125,761	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance		121,900	Advertising: Employee Recruitment		
				FICA Taxes		241,484	Health Care Worker Background Check	1,517	
				Employee Health Insurance		26,623	(Indicate # of checks performed <u>95</u>)		
				Employee Meals		5,218	Patient Background Checks	95 1,518	
				Illinois Municipal Retirement Fund (IMRF)*			Miscellaneous Licenses & Fees	1,721	
							Misc. Publications & Subscriptions	200	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 70,982	Other Employee Benefits		12,158	INHAA Membership Renewal	100	
B. Administrative - Other							Management company allocation	2,668	
Description			Amount						
Management Fees - Eliminated in Col #7			\$ 396,255				Less: Public Relations Expense	()	
							Non-allowable advertising	()	
							Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 396,255	TOTAL (agree to Schedule V, line 22, col.8)		\$ 533,144	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 9,714	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
See Sch 21C	See Sch 21C		\$ 90,731	N/A			Out-of-State Travel	\$	
							In-State Travel		
							Seminar Expense	4,962	
							Management company allocation	1,877	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 90,731	TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	\$ 6,839	

*** 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	3,125
	WW Health Care Consultants LLC	Accounting	1,502
	Purcell & Wardrope	Legal	338
	Kavanagh Grumley & Gorbold, LL	Legal	10,591
	Williams Mullen	Legal	185
	Malmquist & Geiger	Legal/Collections	7,117
	O'Hagan Spencer, LLC	Legal	15,434
	Legal Accrual	Legal	2,929
	Polsinelli Shughart	Legal	1,184
	Quintairos, Prieto	Legal	2,256
....	MDI Achieve	Data Processing	9,020
	WW Health Care Consultants LLC	Data Processing	202
	COMS Interactive, LLC	Data Processing	18,187
	Medifax-EDI, LLC	Data Processing	686
	McGladrey LLP	Accounting	5,200
	Paylocity Payroll	Payroll Processing	12,775
	Line #19 Column 3 Total		<u>90,731</u>
	Less: Nonallowable Legal Fees		(10,046)
	Plus: Allocated from Management Company	Accounting	4,634
	Plus: Allocated from Management Company	Legal	14,308
	Line #19 Column 8 Total		<u><u>99,627</u></u>

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										N/A			
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. INHAA - \$100

(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? 3-10 yrs

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

\$ 30,792 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease. N/A

(9) Are you presently operating under a sublease agreement?

YES X NO

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

YES NO X

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

N/A

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

\$ 247,978

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.

\$ 5,218

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.