

WALKER NURSING HOME, INC.
VIRGINIA, ILLINOIS

FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITY
FOR THE YEAR ENDED SEPTEMBER 30, 2020

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Kerber, Eck & Braeckel LLP
3200 Robbins Road
Suite 200A
Springfield, IL 62704

INDEPENDENT ACCOUNTANTS' PREPARATION REPORT

Board of Directors
Walker Nursing Home, Inc.
Virginia, Illinois

We have prepared the accompanying Financial and Statistical Report for Long-Term Care Facilities for Walker Nursing Home, Inc. for the year ended September 30, 2020 in the form prescribed by the State of Illinois Department of Healthcare and Family Services. We have not audited, reviewed or compiled the accompanying report and, accordingly, do not express an opinion or any other form of assurance about whether the report is in accordance with accounting principles generally accepted in the United States of America or in accordance with the requirements of the State of Illinois Department of Healthcare and Family Services, which are different from accounting principles generally accepted in the United States of America. Accordingly, the Financial and Statistical Report for Long-Term Care Facilities is not designed for those who are not informed about such differences.

Management is responsible for the preparation and fair presentation of the accompanying Financial and Statistical Report for Long-Term Care Facilities in accordance with the requirements of the State of Illinois Department of Healthcare and Family Services, and for designing, implementing, and maintaining internal control relevant to the preparation and fair presentation of the Financial and Statistical Report for Long-Term Care Facilities.

Our responsibility is to prepare the report in accordance with the requirements of the State of Illinois Department of Healthcare and Family Services. The objective of the preparation of the Financial and Statistical Report for Long-Term Care Facilities is to assist management in presenting financial information in the form prescribed by the State of Illinois Department of Healthcare and Family Services without undertaking to obtain or provide any assurance that there are no material modifications that should be made to the Financial and Statistical Report for Long-Term Care Facilities.

A handwritten signature in black ink, appearing to read 'Chris Hahn', is written over a horizontal line.

Springfield, Illinois
January 21, 2021

kebcpa.com

P 217.789.0960
F 217.789.2822

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

IMPORTANT NOTICE

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

I. IDPH License ID Number: 0021428

Facility Name: WALKER NURSING HOME

Address: 530 E BEARDSTOWN ST VIRGINIA 62691

NumberCityZip Code

County: CASS

Telephone Number: 217-452-3218 Fax # 217-452-7746

HFS ID Number:

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

Type of Ownership:

VOLUNTARY,NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code

X PROPRIETARY

Individual

Partnership

Corporation

X "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: CHRIS NELSON Telephone Number: 217-789-0960
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/01/19 to 09/30/20 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) 1/27/2021
(Type or Print Name) RACHEL WHITE
(Title) ADMINISTRATOR

Paid Preparer

(Signed) 1/27/2021
(Print Name and Title) CHRIS NELSON CPA, PARTNER
(Firm Name & Address) KERBER, ECK, & BRAECKEL, LLP 3200 Robbins Rd, Ste 200A, Springfield, IL 62704
(Telephone) 217-789-0960 Fax # 217-789-2822

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number WALKER NURSING HOME

0021428 Report Period Beginning: 10/01/19 Ending: 09/30/20

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	<u>71</u>	Skilled (SNF)	<u>71</u>	<u>25,986</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>71</u>	TOTALS	<u>71</u>	<u>25,986</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF		<u>6,035</u>	<u>260</u>	<u>6,295</u>	8
9	SNF/PED					9
10	ICF	<u>6,215</u>			<u>6,215</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>6,215</u>	<u>6,035</u>	<u>260</u>	<u>12,510</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 48.14%

D. How many bed reserve days during this year were paid by the Department? NONE (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) NONE

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

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

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 01/01/1955

J. Was the facility purchased or leased after January 1, 1978? YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter number of beds certified 71 and days of care provided 260

Medicare Intermediary WISCONSIN PHYSICIAN SERVICES

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 09/30/20 Fiscal Year: 09/30/20
* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number **WALKER NURSING HOME** # **0021428** Report Period Beginning: **10/01/19** Ending: **09/30/20**
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	141,790	3,391	2,838	148,019		148,019		148,019			1
2	Food Purchase		113,609		113,609		113,609		113,609			2
3	Housekeeping	59,603	3,717		63,320		63,320		63,320			3
4	Laundry	49,285	131		49,416		49,416		49,416			4
5	Heat and Other Utilities			64,499	64,499		64,499		64,499			5
6	Maintenance	56,179	3,909	17,118	77,206		77,206		77,206			6
7	Other (specify):*			13,958	13,958		13,958		13,958			7
8	TOTAL General Services	306,857	124,757	98,413	530,027		530,027		530,027			8
	B. Health Care and Programs											
9	Medical Director			6,750	6,750		6,750		6,750			9
10	Nursing and Medical Records	1,072,419	47,778	9,634	1,129,831		1,129,831		1,129,831			10
10a	Therapy			104,808	104,808		104,808		104,808			10a
11	Activities	36,797	2,479	5,100	44,376		44,376		44,376			11
12	Social Services	37,386			37,386		37,386		37,386			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*			57,869	57,869		57,869		57,869			15
16	TOTAL Health Care and Programs	1,146,602	50,257	184,161	1,381,020		1,381,020		1,381,020			16
	C. General Administration											
17	Administrative	123,271			123,271		123,271		123,271			17
18	Directors Fees											18
19	Professional Services			36,838	36,838		36,838	(13,877)	22,961			19
20	Dues, Fees, Subscriptions & Promotions			3,210	3,210		3,210	(1,055)	2,155			20
21	Clerical & General Office Expenses	14,379	7,309	54,824	76,512		76,512		76,512			21
22	Employee Benefits & Payroll Taxes			179,972	179,972		179,972		179,972			22
23	Inservice Training & Education			8,392	8,392		8,392		8,392			23
24	Travel and Seminar			2,912	2,912		2,912		2,912			24
25	Other Admin. Staff Transportation			6,699	6,699		6,699		6,699			25
26	Insurance-Prop.Liab.Malpractice			34,878	34,878		34,878		34,878			26
27	Other (specify):*											27
28	TOTAL General Administration	137,650	7,309	327,725	472,684		472,684	(14,932)	457,752			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,591,109	182,323	610,299	2,383,731		2,383,731	(14,932)	2,368,799			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Other General Services - Line 7 (3)		Amount	Travel and Seminar - Line 24 (3)		Amount
Trash Removal		4,627	IHCA Meeting		175
Alarm Monitoring		9,331	Restorative Nursing Class		1,507
		13,958	CPR Class		300
			Food Management Class		550
Other Health Care & Programs - Line 15 (3)			Food Handler's Class		130
			IL NHAA Workshops		250
Medical Waste Removal		1,712			2,912
Pest Control		1,523			
Sanitation costs related to COVID infections		19,860			
PPE and other infection control supplies		34,774			
		57,869			
Inservice Training & Education - Line 23 (3)		Amount	Other Admin. Staff Travel		
			& Transportation - Line 25 (3)		Amount
Health Care Academy - Course Licenses		2,500			
Reliance Learning - Monthly Staff Training videos		4,892	Fuel		6,584
RN Tuition Reimbursement		1,000	Vehicle Repairs		115
		8,392			6,699

SEE ACCOUNTANTS' PREPARATION REPORT

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			48,485	48,485		48,485	(7,052)	41,433			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			16,853	16,853		16,853		16,853			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			8,208	8,208		8,208		8,208			35
36	Other (specify):*											36
37	TOTAL Ownership			73,546	73,546		73,546	(7,052)	66,494			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,606	1,542	3,148		3,148		3,148			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			114,262	114,262		114,262		114,262			42
43	Other (specify):*			183,888	183,888		183,888	(183,888)				43
44	TOTAL Special Cost Centers		1,606	299,692	301,298		301,298	(183,888)	117,410			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,591,109	183,929	983,537	2,758,575		2,758,575	(205,872)	2,552,703			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Other - Line 43, Column 3	Amount
Bad Debt Expense	161,729
Contributions	1,375
Advertising	3,364
Medicare Services - Part A	7,354
FED Penalites	1,020
IDPH Penalties	9,046
	183,888

SEE ACCOUNTANTS' PREPARATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(7,052)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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	(10,066)	43		18
19	Entertainment				19
20	Contributions	(1,375)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(13,877)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(161,729)	43		24
25	Fund Raising, Advertising and Promotional	(1,055)	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	(10,718)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (205,872)		\$	30

BHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (205,872)		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

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Advertising	\$ (3,364)	43	1
2	Medicare Services	(7,354)	43	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
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40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(10,718)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WALKER NURSING HOME# 0021428

Report Period Beginning:

10/01/19

Ending:

09/30/20

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	(13,877)	0	0	0	0	0	0	0	0	0	0	(13,877)	19
20	Fees, Subscriptions & Promotions	(1,055)	0	0	0	0	0	0	0	0	0	0	(1,055)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(14,932)	0	0	0	0	0	0	0	0	0	0	(14,932)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(14,932)	0	0	0	0	0	0	0	0	0	0	(14,932)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WALKER NURSING HOME # 0021428 Report Period Beginning: 10/01/19 Ending: 09/30/20

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	(7,052)	0	0	0	0	0	0	0	0	0	0	(7,052)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(7,052)	0	0	0	0	0	0	0	0	0	0	(7,052)	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):*	(183,888)	0	0	0	0	0	0	0	0	0	0	(183,888)	43
44	TOTAL Special Cost Centers	(183,888)	0	0	0	0	0	0	0	0	0	0	(183,888)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(205,872)	0	0	0	0	0	0	0	0	0	0	(205,872)	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
GEORGE W. WHITE	50	N/A		N/A		
MARY ANN WHITE	50	N/A		N/A		

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

YES

X 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			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number WALKER NURSING HOME # 0021428 Report Period Beginning: 10/01/19 Ending: 09/30/20

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	George W White	Vice-President	Maintenance	50.00	0	20	100.00	Salary	\$ 24,132	6 (1)	1
2											2
3	Rachel White	None	Administrator	0.00	0	40	100.00	Salary	65,757	17 (1)	3
4											4
5	Bryan White	None	Asst. Admin	0.00	0	32	80.00	Salary	57,514	17 (1)	5
6			Clerical	0.00	0	8	20.00	Salary	14,379	21 (1)	6
7											7
8	Mary Ann White	President	Retired	50.00	0	0	0.00	n/a			8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 161,782		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

SEE ACCOUNTANTS' PREPARATION REPORT

Ending: 09/30/20

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

SEE ACCOUNTANTS' PREPARATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

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

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' PREPARATION REPORT

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

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 2019 report.			\$	18,665	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.)			\$	20,296	2
3. Under or (over) accrual (line 2 minus line 1).			\$	1,631	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	15,222	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.			\$	16,853	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2015	23,970	8	
		2016	24,258	9	
		2017	24,884	10	
		2018	24,887	11	
		2019	20,296	12	
				13	FOR BHF USE ONLY
				13	FROM R. E. TAX STATEMENT FOR 2019 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' PREPARATION REPORT

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WALKER NURSING HOME COUNTY CASS

FACILITY IDPH LICENSE NUMBER 0021428

CONTACT PERSON REGARDING THIS REPORT Chris Nelson or Stephanie Prather

TELEPHONE 217-789-0960 FAX #: 217-789-2822

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2019 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 2019.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 09-033-009-00	Lot	\$ 524.08	\$ 524.08
2. 11-052-009-00	Lot	\$ 426.68	\$ 426.68
3. 11-087-007-00	Lot / Building	\$ 19,345.38	\$ 19,345.38
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 20,296.14	\$ 20,296.14

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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.

TRAVIS COX
CASS COUNTY TREASURER
PO BOX 167
VIRGINIA, IL 62691

FIRST INSTALLMENT		SECOND INSTALLMENT	
DUE DATE	07/17/2020	DUE DATE	09/04/2020
INST AMT	\$262.04	INST AMT	\$262.04
AMT PAID	\$0.00	AMT PAID	\$0.00
TOTAL	\$262.04	TOTAL	\$262.04

PROPERTY DESC:
S 53' OF LOTS 5 & 6 BLK 1E ORIGINAL TOWN (53' X 100')

9401

NAME:
WALKER NURSING HOME INC
530 E BEARDSTOWN ST
VIRGINIA IL 62691-0000

OWNER NAME:
WALKER NURSING HOME INC
530 E BEARDSTOWN ST
VIRGINIA, IL 62691-0000

2018 TAXABLE VALUE	CASS COUNTY ITEMIZED STATEMENT	2019 TAXABLE VALUE
5,655		5,710

TAX RATE	TAX AMOUNT		TAX RATE	TAX AMOUNT	% OF TOTAL	PENSION AMOUNT
0.25000	\$14.14	AMBULANCE SERVICE	0.25000	\$14.28	2.72	\$0.00
0.20800	\$11.76	COUNTY HIGHWAY	0.20800	\$11.88	2.27	\$0.00
1.04033	\$58.85	COUNTY TAX	0.95602	\$54.57	10.42	\$15.23
0.02995	\$1.69	EXTENSION SERVICE	0.02901	\$1.66	0.32	\$0.00
0.07188	\$4.06	MENTAL HEALTH DEPT	0.06963	\$3.98	0.76	\$0.00
0.07668	\$4.34	PUBLIC HEALTH DEPT	0.07427	\$4.24	0.81	\$0.00
0.49027	\$27.72	LINCOLN LAND JC526	0.49405	\$28.21	5.38	\$0.46
0.02075	\$1.17	MULTI-TWP ASSMT #3	0.01991	\$1.14	0.22	\$0.00
0.40779	\$23.06	PHILADELPHIA TWP	0.40722	\$23.25	4.44	\$4.82
0.56525	\$31.96	PHILADELPHIA R&B	0.56086	\$32.03	6.11	\$0.00
6.17347	\$349.11	UNIT SCHOOL 64	6.10931	\$348.84	66.56	\$21.42
9.33437	\$527.86	*TOTALS*	9.17828	\$524.08	100.00	

2019 CASS COUNTY
REAL ESTATE TAX BILL

PERMANENT PROPERTY NUMBER
09-033-009-00

TOWNSHIP Philadelphia	FAIR CASH VALUE 17,130
LAND/LOT ACRES 0.00	LAND/LOT 420
FARMLAND ACRES 0.00	+ BLDG 5,290
TAX CODE 09001	= ASSESSED VALUE 5,710
CLASS CODE 0040	- HIE /HI VET EXEMPT 0
LENDING CODE	= VALUE TO BE EQUALIZED 5,710
TIF TAXABLE VALUE 0	x STATE MULTIPLIER 1.0000
FORFEITED TAX	= EQUALIZED VALUE 5,710
	- OWNER OCCUPIED 0
	- SENIOR HOMESTEAD 0
	- SENIOR FREEZE 0
	- RETURNING VETERAN 0
	- DISABLED VET/PERSON 0
	- NATURAL DISASTER 0
	- FRAT FREEZE 0
	+ FARM LAND / MINERAL VALUE 0
	+ FARM BUILDINGS 0
	= TAXABLE VALUE 5,710
	x TAX RATE 9.17828
	= TOTAL TAX \$524.08
	- ENTERPRISE ZONE ABATE \$0.00
	= TOTAL AMOUNT DUE \$524.08

SEND COUPON WITH PAYMENT OR DUPLICATE BILL FEE OF \$2.50 WILL BE CHARGED.
PENALTY ADDED AFTER DUE DATE PER STATUTE.

Registration
Code #: 919969

Name or Address change? ☐ Check box and write information on reverse side

Name or Address change? ☐ Check box and write information on reverse side

HFS 3745 (N-4-99)

IL478-2471

TRAVIS COX
CASS COUNTY TREASURER
PO BOX 167
VIRGINIA, IL 62691

FIRST INSTALLMENT	SECOND INSTALLMENT
DUE DATE 07/17/2020	DUE DATE 09/04/2020
INST AMT \$213.34	INST AMT \$213.34
AMT PAID \$0.00	AMT PAID \$0.00
TOTAL \$213.34	TOTAL \$213.34

PROPERTY DESC:
S 45' LOT 69 H H HALL'S ADD OF 1837 (45' X 60')

9402

NAME:
WALKER NURSING HOME INC
530 E BEARDSTOWN ST
VIRGINIA IL 62691-0000

OWNER NAME:
WALKER NURSING HOME INC,
530 E BEARDSTOWN ST
VIRGINIA, IL 62691-0000

2018 TAXABLE VALUE
3,940

CASS COUNTY
ITEMIZED STATEMENT

2019 TAXABLE VALUE
3,980

TAX RATE	TAX AMOUNT	TAX RATE	TAX AMOUNT	% OF TOTAL	PENSION AMOUNT
0.25000	\$9.85	0.25000	\$9.95	2.33	\$0.00
0.20800	\$8.20	0.20800	\$8.28	1.94	\$0.00
1.04033	\$40.99	0.95602	\$38.07	8.92	\$10.63
0.02995	\$1.18	0.02901	\$1.15	0.27	\$0.00
0.07188	\$2.83	0.06963	\$2.77	0.65	\$0.00
0.07668	\$3.02	0.07427	\$2.96	0.69	\$0.00
0.49027	\$19.32	0.49405	\$19.66	4.61	\$0.32
0.02075	\$0.82	0.01991	\$0.79	0.19	\$0.00
0.31756	\$12.51	0.30691	\$12.22	2.86	\$0.00
0.30362	\$11.96	0.30486	\$12.13	2.84	\$0.00
6.17347	\$243.23	6.10931	\$243.15	56.99	\$14.92
1.72357	\$67.91	1.76570	\$70.27	16.47	\$9.06
0.13565	\$5.34	0.13266	\$5.28	1.24	\$0.00
10.84173	\$427.16	10.72033	\$426.68	100.00	

PERMANENT PROPERTY NUMBER
11-052-009-00

TOWNSHIP Virginia	FAIR CASH VALUE 11,940
LAND/LOT ACRES 0.00	LAND/LOT 565
FARMLAND ACRES 0.00	+ BLDG 3,415
TAX CODE 11002	= ASSESSED VALUE 3,980
CLASS CODE 0040	- HIE /HI VET EXEMPT 0
LENDING CODE	= VALUE TO BE EQUALIZED 3,980
TIF TAXABLE VALUE 0	x STATE MULTIPLIER 1.0000
FORFEITED TAX	= EQUALIZED VALUE 3,980
	- OWNER OCCUPIED 0
	- SENIOR HOMESTEAD 0
	- SENIOR FREEZE 0
	- RETURNING VETERAN 0
	- DISABLED VET/PERSON 0
	- NATURAL DISASTER 0
	- FRAT FREEZE 0
	+ FARM LAND / MINERAL VALUE 0
	+ FARM BUILDINGS 0
	= TAXABLE VALUE 3,980
	x TAX RATE 10.72033
	= TOTAL TAX \$426.68
	- ENTERPRISE ZONE ABATE \$0.00
	= TOTAL AMOUNT DUE \$426.68

SEND COUPON WITH PAYMENT OR DUPLICATE BILL FEE OF \$2.50 WILL BE CHARGED.
PENALTY ADDED AFTER DUE DATE PER STATUTE.

Registration
Code #: 919969

Name or Address change?

☐ Check box and write information on reverse side

Name or Address change?

☐ Check box and write information on reverse side

HFS 3745 (N-4-99)

IL478-2471

TRAVIS COX
CASS COUNTY TREASURER
PO BOX 167
VIRGINIA, IL 62691

FIRST INSTALLMENT		SECOND INSTALLMENT	
DUE DATE	07/17/2020	DUE DATE	09/04/2020
INST AMT	\$9,672.69	INST AMT	\$9,672.69
AMT PAID	\$0.00	AMT PAID	\$0.00
TOTAL	\$9,672.69	TOTAL	\$9,672.69

PROPERTY DESC:
LOT 3 EXC 4 2/5' OFF E SD ALSO 31.3' X 45' NW COR
OF LOT 7 & LOTS 4, 5 & 6 & 45' N SD. LOT 9 BLK 3
BEER'S CHESTON HILL ADD

9403

NAME:
WALKER NURSING HOME INC
530 E BEARDSTOWN ST
VIRGINIA IL 62691-0000

OWNER NAME:
WALKER NURSING HOME INC
530 E BEARDSTOWN ST
VIRGINIA, IL 62691-0000

2018 TAXABLE VALUE	CASS COUNTY ITEMIZED STATEMENT	2019 TAXABLE VALUE
220,735		180,455

TAX RATE	TAX AMOUNT	
0.25000	\$551.84	AMBULANCE SERVICE
0.20800	\$459.13	COUNTY HIGHWAY
1.04033	\$2,296.37	COUNTY TAX
0.02995	\$66.11	EXTENSION SERVICE
0.07188	\$158.66	MENTAL HEALTH DEPT
0.07668	\$169.26	PUBLIC HEALTH DEPT
0.49027	\$1,082.20	LINCOLN LAND JC526
0.02075	\$45.80	MULTI-TWP ASSMT #3
0.31756	\$700.97	VIRGINIA TWP
0.30362	\$670.20	VIRGINIA R&B
6.17347	\$13,627.01	UNIT SCHOOL 64
1.72357	\$3,804.52	VIRGINIA CORP
0.13565	\$299.43	VIRGINIA LIB DIST
10.84173	\$23,931.50	

TOTALS

TAX RATE	TAX AMOUNT	
0.25000	\$451.14	
0.20800	\$375.35	
0.95602	\$1,725.19	
0.02901	\$52.35	
0.06963	\$125.65	
0.07427	\$134.02	
0.49405	\$891.54	
0.01991	\$35.93	
0.30691	\$553.83	
0.30486	\$550.14	
6.10931	\$11,024.56	
1.76570	\$3,186.29	
0.13266	\$239.39	
10.72033	\$19,345.38	

% OF TOTAL	PENSION AMOUNT	
2.33	\$0.00	
1.94	\$0.00	
8.92	\$481.62	
0.27	\$0.00	
0.65	\$0.00	
0.69	\$0.00	
4.61	\$14.65	
0.19	\$0.00	
2.86	\$0.00	
2.84	\$0.00	
56.99	\$676.74	
16.47	\$410.99	
1.24	\$0.00	

2019 CASS COUNTY
REAL ESTATE TAX BILL

PERMANENT PROPERTY NUMBER
11-087-007-00

TOWNSHIP	Virginia	FAIR CASH VALUE	541,420
LAND/LOT ACRES	0.00	LAND/LOT	10,485
FARMLAND ACRES	0.00	+ BLDG	169,970
TAX CODE	11002	= ASSESSED VALUE	180,455
CLASS CODE	0060	- HIE /HI VET EXEMPT	0
LENDING CODE		= VALUE TO BE EQUALIZED	180,455
TIF TAXABLE VALUE	0	x STATE MULTIPLIER	1.0000
FORFEITED TAX		= EQUALIZED VALUE	180,455
		- OWNER OCCUPIED	0
		- SENIOR HOMESTEAD	0
		- SENIOR FREEZE	0
		- RETURNING VETERAN	0
		- DISABLED VET/PERSON	0
		- NATURAL DISASTER	0
		- FRAT FREEZE	0
		+ FARM LAND / MINERAL VALUE	0
		+ FARM BUILDINGS	0
		= TAXABLE VALUE	180,455
		x TAX RATE	10.72033
		= TOTAL TAX	\$19,345.38
		- ENTERPRISE ZONE ABATE	\$0.00
		= TOTAL AMOUNT DUE	\$19,345.38

SEND COUPON WITH PAYMENT OR DUPLICATE BILL FEE OF \$2.50 WILL BE CHARGED.
PENALTY ADDED AFTER DUE DATE PER STATUTE.

Registration
Code #: 919969

Name or Address change? ☐ Check box and write information on reverse side

Name or Address change? ☐ Check box and write information on reverse side

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,040

B. General Construction Type: Exterior BrickFrame Wood & Steel

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: 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	Resident Care	22,176	1955	\$ 11,000	1
2	Resident Care	9,504	1981	23,604	2
3	TOTALS	31,680		\$ 34,604	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number WALKER NURSING HOME

0021428

Report Period Beginning:

10/01/19

Ending:

09/30/20

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	Concrete Work for Entrance and Walkways	2007	\$ 64,272	\$ 3,214	20	\$ 3,214	\$	\$ 36,957	37
38	Manor Landscaping Improvements	2007	10,560	528	20	528		7,116	38
39	Toilets & Installation	2008	4,354		20			4,354	39
40	New Railings	2008	6,315	158	39	162	4	3,180	40
41	Iron Fence	2008	4,895	245	20	245		3,062	41
42	Major Landscaping	2008	11,701	586	20	585	(1)	7,317	42
43	Water Heater	2009	5,998	150	40	150		1,725	43
44	Air Conditioner - 10 ton	2009	9,995	250	40	250		2,875	44
45	Water Heater	2009	5,140	129	40	129		1,480	45
46	6 Heating & Cooling Units	2009	3,356		10			3,356	46
47	Sprinkler Systems	2010	45,130	1,218	20	2,257	1,039	22,268	47
48	Nurse Call System	2010	48,241	4,423	20	2,412	(2,011)	25,326	48
49	Furnish & Install Blinds & Valances	2010	9,970	318	20	499	181	3,992	49
50	Install Door Alarm System	2010	19,350	484	40	484		4,598	50
51	New Roof on Hall E	2010	31,927	798	40	798		7,581	51
52	Installation of 5 Ton Roof top Unit	2011	7,790	195	20	195		1,950	52
53	Install New Furnace & Air Conditioner	2011	5,700	143	40	143		1,358	53
54	Install Dry Valve w/ Trim Sprinkler	2011	4,929	123	40	123		1,169	54
55	Remove/replace 3 doors	2011	2,627	66	40	66		528	55
56	6 New Cooling Units for Resident Rooms	2011	4,246	425	10	425		3,400	56
57	Generator	2012	58,045	2,902	20	2,902		15,962	57
58	Security Cameras	2013	2,726	273	10	273		1,934	58
59	Tile Flooring - Nurses Station	2013	2,737	68	40	68		482	59
60	New Windows	2013	5,586	140	40	140		1,015	60
61	Generator	2014	5,081	333	20	254	(79)	1,778	61
62	New Roof on Shed	2014	7,287	182	40	182		1,122	62
63	New South Furnace & Cooling System	2014	6,318	158	40	158		961	63
64	New Energy Control System	2015	11,338	756	20	567	(189)	2,882	64
65	New Roof Top A/C Unit	2015	11,640	776	20	582	(194)	2,959	65
66	New Brick Wall & Concrete Work	2016	3,425	171	20	171		841	66
67	New Roof A/C	2016	3,634	242	20	182	(60)	773	67
68	New Tile & Installation - North Hall	2017	5,627	141	40	141		552	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,805,752	\$ 26,692		\$ 25,683	\$ (1,009)	\$ 1,451,400	70

SEE ACCOUNTANTS' PREPARATION REPORT

**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		\$ 1,805,752	\$ 26,692		\$ 25,683	\$ (1,009)	\$ 1,451,400	1
2 New Water Heater & Installation	2017	8,656	866	10	866		3,319	2
3 North Hall - New Water Heater & Install	2017	8,615	862	10	862		2,945	3
4 Concrete Work - Sidewalks	2019	3,805	190	20	190		349	4
5 Roof Repairs	2019	3,017	151	20	151		201	5
6 Electrical Outlet Upgrade	2020	3,280	68	20	68		68	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 TOTAL (lines 1 thru 33)		\$ 1,833,125	\$ 28,829		\$ 27,820	\$ (1,009)	\$ 1,458,282	34

SEE ACCOUNTANTS' PREPARATION REPORT

**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	\$ 69,960	\$ 16,209	\$ 9,269	\$ (6,940)	various	\$ 51,071	71
72	Current Year Purchases	7,093	760	760		7	760	72
73	Fully Depreciated Assets	843,376				various	843,376	73
74								74
75	TOTALS	\$ 920,429	\$ 16,969	\$ 10,029	\$ (6,940)		\$ 895,207	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Care	Handicap Bus	2002	\$ 44,983	\$	\$	\$	5	\$ 44,983	76
77	Resident Care	2008 Chevy Van	2014	12,999	1,392	1,857	465	7	11,452	77
78	Resident Care	Reconditioned Bus	2014	12,090	1,295	1,727	432	7	10,362	78
79										79
80	TOTALS			\$ 70,072	\$ 2,687	\$ 3,584	\$ 897		\$ 66,797	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,858,230	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 48,485	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 41,433	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (7,052)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,420,286	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' PREPARATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .
9. Option to Buy: ☐ YES ☐ NO Terms: *

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: \$ 8,208 Description: SEE ATTACHMENT SCHEDULE 14A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' PREPARATION REPORT

SCHEDULE 14 A

XII. RENTAL COSTS	
LINE 16 DESCRIPTION	Amount
ICE MACHINE	1,440
DISHWASHER	828
AIR SCRUBBER MACHINES	5,300
OXYGEN CONCENTRATORS	640
	8,208

SEE ACCOUNTANTS' PREPARATION REPORT

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

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' PREPARATION REPORT

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	L10A C3	hrs	\$	319	\$ 25,660	\$	319	\$ 25,660	1
2	Licensed Speech and Language Development Therapist	L10A C3	hrs		797	8,962		797	8,962	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A C3	hrs		43	70,186		43	70,186	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39 C2	# of prescrpts				1,606		1,606	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)									
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	1,159	\$ 104,808	\$ 1,606	1,159	\$ 106,414	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' PREPARATION REPORT

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	\$ 525,413	\$ 525,413	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	317,704	317,704	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	201,067	201,067	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	425	425	7
8	Accounts Receivable (owners or related parties)	108,403	108,403	8
9	Other(specify):	919	2,311	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,153,931	\$ 1,155,323	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	34,604	34,604	13
14	Buildings, at Historical Cost	1,022,052	979,242	14
15	Leasehold Improvements, at Historical Cost	753,991	853,884	15
16	Equipment, at Historical Cost	1,073,840	990,501	16
17	Accumulated Depreciation (book methods)	(2,419,191)	(2,420,286)	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)	\$ 465,296	\$ 437,945	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,619,227	\$ 1,593,268	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 70,558	\$ 70,557	26
27	Officer's Accounts Payable	15,332	15,332	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	42,641	42,641	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	15,222	15,222	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)	\$ 143,753	\$ 143,752	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	SBA PPP Loan	281,654	281,654	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 281,654	\$ 281,654	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 425,407	\$ 425,406	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,193,820	\$ 1,167,862	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,619,227	\$ 1,593,268	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,217,650	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,217,650	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(23,830)	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)	\$ (23,830)	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)	\$ 1,193,820	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number WALKER NURSING HOME

0021428

Report Period Beginning: 10/01/19

Ending:

09/30/20

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

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,204,806	1
2	Discounts and Allowances for all Levels	(12,015)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,192,791	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions	118,255	24
25	Interest and Other Investment Income***	3,131	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 121,386	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>HHS Stimulus Funds</u>	420,446	28
28a	<u>Refunds</u>	122	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 420,568	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,734,745	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	530,027	31
32	Health Care	1,381,020	32
33	General Administration	472,684	33
	B. Capital Expense		
34	Ownership	73,546	34
	C. Ancillary Expense		
35	Special Cost Centers	301,298	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)*	\$ 2,758,575	40
41	Income before Income Taxes (line 30 minus line 40)**	(23,830)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (23,830)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 672,297	44
45	Private Pay - Net Inpatient Revenue	1,308,521	45
46	Medicare - Net Inpatient Revenue	120,994	46
47	Other-(specify) <u>Insurance</u>	90,979	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,192,791	49

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,218	2,330	\$ 81,649	\$ 35.04	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,041	4,293	147,869	34.44	3
4	Licensed Practical Nurses	14,056	14,280	383,960	26.89	4
5	CNAs & Orderlies	29,020	29,429	466,368	15.85	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,837	1,845	37,386	20.26	8
9	Activity Director	1,872	1,947	23,366	12.00	9
10	Activity Assistants	1,396	1,396	13,431	9.62	10
11	Social Service Workers					11
12	Dietician	1,694	1,734	26,682	15.39	12
13	Food Service Supervisor	927	1,031	19,917	19.32	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,943	7,973	87,764	11.01	15
16	Dishwashers					16
17	Maintenance Workers	3,091	3,171	56,179	17.72	17
18	Housekeepers	4,842	4,926	59,603	12.10	18
19	Laundry	3,555	3,701	49,285	13.32	19
20	Administrator	2,099	2,099	65,757	31.33	20
21	Assistant Administrator	1,680	1,680	57,514	34.23	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	420	420	14,379	34.24	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)	80,691	82,255	\$ 1,591,109 *	\$ 19.34	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	53	\$ 2,838	1(3)	35
36	Medical Director	Monthly	6,750	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	5,100	11(3)	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Psychiatric Consultant	Monthly	6,000	10(3)	47
48					48
49	TOTAL (lines 35 - 48)	53	\$ 20,688		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	44	\$ 3,005	10(3)	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	16	629	10(3)	52
53	TOTAL (lines 50 - 52)	60	\$ 3,634		53

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number		WALKER NURSING HOME		STATE OF ILLINOIS		# 0021428		Report Period Beginning:		10/01/19		Page 21		Ending: 09/30/20					
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					
RACHEL WHITE		Administrator		0		\$ 65,757		Workers' Compensation Insurance		\$ 17,170		IDPH License Fee		\$					
BRYAN WHITE		Asst Administrator		0		57,514		Unemployment Compensation Insurance		7,270		Advertising: Employee Recruitment		819					
								FICA Taxes		121,883		Health Care Worker Background Check							
								Employee Health Insurance		30,868		(Indicate # of checks performed)							
								Employee Meals				Patient Background Checks		200					
								Illinois Municipal Retirement Fund (IMRF)*				PUBLIC RELATIONS		1,055					
								EMPLOYEE BENEFITS		2,781		OTHER LICENSE FEES		711					
TOTAL (agree to Schedule V, line 17, col. 1)												ASSOCIATION DUES				250			
(List each licensed administrator separately.)				\$ 123,271								SUBSCRIPTIONS				175			
B. Administrative - Other																			
Description						Amount						Less: Public Relations Expense		(1,055)					
						\$						Non-allowable advertising		()					
												Yellow page advertising		()					
												TOTAL (agree to Sch. V,		\$ 2,155					
								TOTAL (agree to Schedule V,		\$ 179,972		line 20, col. 8)							
								line 22, 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											
C. Professional Services																			
Vendor/Payee		Type				Amount		Description		Line #		Amount		Description		Amount			
						\$						\$		Out-of-State Travel		\$			
Cavanagh & O'Hara		Legal Services				715													
KEB, LLP		Accounting				22,773													
Cogency Global Inc		Annual Corp Report				188								In-State Travel					
Duane Morris LLP		IDPH Claim				13,162													
TOTAL (agree to Schedule V, line 19, column 3)				\$ 36,838				TOTAL				\$				Seminar Expense			
(For legal fee disclosure, see page 39 of instructions)																SEE PAGE 3A		2,912	
																Entertainment Expense		()	
																(agree to Sch. V,			
																TOTAL line 24, col. 8)		\$ 2,912	

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL NURSING HOME ADMIN - \$250
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line 10(2)
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 114,262
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? YES-PG 7 If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? NO Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 0
- d. Have vehicle usage logs been maintained? Adequate Records have been maintained
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
- g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' PREPARATION REPORT