FOR BHF USE

LL1

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.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0021428

Facility Name: Walker Nursing Home

Address: 530 East Beardstown Street (Number) Virginia (City) 62691 (Zip 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	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Michael W. Martin **Telephone Number:** (217) 258-8888
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 10/01/09 to 09/30/10 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) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title)
(Firm Name & Address) McGladrey & Pullen, 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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/01/09 Ending: 09/30/10

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	71	Skilled (SNF)	71	25,915	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	71	TOTALS	71	25,915	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	366	4,952	2,120	7,438	8
9	SNF/PED					9
10	ICF	9,062			9,062	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,428	4,952	2,120	16,500	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.67%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] 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 [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/55

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 71 and days of care provided 2,120

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 09/30/10 Fiscal Year: 09/30/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/01/09 Ending: 09/30/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	122,516	984	5,376	128,876		128,876		128,876			1
2	Food Purchase		130,731		130,731		130,731	(359)	130,372			2
3	Housekeeping	48,162	1,190		49,352		49,352	2,054	51,406			3
4	Laundry	47,218	4,646		51,864		51,864		51,864			4
5	Heat and Other Utilities			70,237	70,237		70,237		70,237			5
6	Maintenance	20,468	14,567	34,854	69,889		69,889	781	70,670			6
7	Other (specify):*											7
8	TOTAL General Services	238,364	152,118	110,467	500,949		500,949	2,476	503,425			8
	B. Health Care and Programs											
9	Medical Director							3,685	3,685			9
10	Nursing and Medical Records	761,159	33,037	8,990	803,186		803,186		803,186			10
10a	Therapy			272,568	272,568		272,568		272,568			10a
11	Activities	20,496	4,472	5,100	30,068		30,068		30,068			11
12	Social Services	33,664			33,664		33,664		33,664			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	815,319	37,509	286,658	1,139,486		1,139,486	3,685	1,143,171			16
	C. General Administration											
17	Administrative	105,159			105,159		105,159		105,159			17
18	Directors Fees											18
19	Professional Services			51,677	51,677		51,677	(14,601)	37,076			19
20	Dues, Fees, Subscriptions & Promotions			4,197	4,197		4,197		4,197			20
21	Clerical & General Office Expenses	50,945	13,931	18,851	83,727		83,727		83,727			21
22	Employee Benefits & Payroll Taxes			185,012	185,012		185,012	359	185,371			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,748	4,748		4,748		4,748			24
25	Other Admin. Staff Transportation			6,581	6,581		6,581		6,581			25
26	Insurance-Prop.Liab.Malpractice			40,739	40,739		40,739		40,739			26
27	Other (specify):*											27
28	TOTAL General Administration	156,104	13,931	311,805	481,840		481,840	(14,242)	467,598			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,209,787	203,558	708,930	2,122,275		2,122,275	(8,081)	2,114,194			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Walker Nursing Home #0021428 Report Period Beginning: 10/01/09 Ending: 09/30/10

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			33,491	33,491		33,491	13,163	46,654			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			24,550	24,550		24,550		24,550			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			2,363	2,363		2,363		2,363			35
36	Other (specify):*											36
37	**TOTAL Ownership**			60,404	60,404		60,404	13,163	73,567			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		52,291	3,828	56,119		56,119	(3,685)	52,434			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			38,873	38,873		38,873		38,873			42
43	Other (specify):* Non-Allowable Cos			65,539	65,539		65,539	(65,539)				43
44	**TOTAL Special Cost Centers**		52,291	108,240	160,531		160,531	(69,224)	91,307			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,209,787	255,849	877,574	2,343,210		2,343,210	(64,142)	2,279,068			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/01/09 Ending: 09/30/10

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	13,163	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	(222)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(922)	43		19
20	Contributions	(285)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(14,601)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(9,297)	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	(51,978)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (64,142)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (64,142)		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' COMPILATION REPORT

Walker Nursing Home

ID# 0021428

Report Period Beginning: 10/01/09

Ending: 09/30/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Medicare Services	$ (8,194)	43	1
2	Labs - Medicare	(9,134)	43	2
3	X-Rays Medicare	(6,194)	43	3
4	Medical Supplies - Medicare	(31,144)	43	4
5	Clothing Residents	(147)	43	5
6	Repairs & Maintenance -Supplies	781	6	6
7	Housekeeping - Supplies	2,054	3	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**	(51,978)		49

See Accountant's Compilation Report

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/01/09 Ending: 09/30/10

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
George M. 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V				N/A				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' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/01/09 Ending: 09/30/10

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mary Ann White	President	Co-Administrator	50.00	0	13	40.00	Salary	$ 16,800	17(1)	1
2			Office Manager			19	60.00	Salary	25,200	21(1)	2
3											3
4	George W. White	Vice President	Co-Administrator	50.00	0	0	45.00	Salary	16,747	17(1)	4
5			Maintenance			0	55.00	Salary	20,468	6(1)	5
6											6
7	Bryan White	None	Asst. Admin	0.00	0	32	80.00	Salary	35,793	17(1)	7
8			Clerical			8	20.00	Salary	8,948	21(1)	8
9											9
10	Rachel White	None	Asst. Admin	0.00	0	32	80.00	Salary	35,819	17(1)	10
11			Clerical			8	20.00	Salary	8,955	21(1)	11
12											12
13								TOTAL	$ 168,730		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' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/01/09 Ending: 09/30/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3				N/A						3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/01/09 Ending: 09/30/10

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/01/09 Ending: 09/30/10

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 21,705	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.)	2009	$ 24,550	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,845	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 21,705	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.		$ 24,550	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005	27,408	8
2006	25,764	9
2007	24,768	10
2008	25,316	11
2009	24,550	12

Accrual based on 9/12 of current real estate tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	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' COMPILATION REPORT

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Walker Nursing Home COUNTY Cass

FACILITY IDPH LICENSE NUMBER 0021428

CONTACT PERSON REGARDING THIS REPORT Jeff Swanberg

TELEPHONE (217) 789-7700 FAX #: (217) 753-1654

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-033-009-00	Lot	$ 511.42	$ 511.42
2.	11-052-009-00	Lot	$ 449.38	$ 449.38
3.	11-087-007-00	Lot	$ 23,589.16	$ 23,589.16
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 24,549.96	$ 24,549.96

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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/01/09 Ending: 09/30/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,040 B. General Construction Type: Exterior Brick Frame Wood and Steel Number of Stories 1

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

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

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

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

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

None

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

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

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	22,176	1955	$ 11,000	1
2	Resident Care	9,504	1981	23,604	2
3	TOTALS	31,680		$ 34,604	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/01/09 Ending: 09/30/10

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	20		1972	1972	$ 130,523	$	30	$	$	$ 130,523	4
5	30		1977	1977	363,607		30			363,607	5
6	5		1981	1981	79,226		30	2,641	2,641	78,519	6
7	16		1985	1985	399,782		30	13,326	13,326	333,146	7
8											8
	Improvement Type**										
9	Leasehold Improvement			1974	900		Various			900	9
10	Leasehold Improvement			1975	200		Various			200	10
11	Leasehold Improvement			1977	2,889		Various			2,889	11
12	Leasehold Improvement			1982	552		Various			552	12
13	Leasehold Improvement			1983	533		Various			533	13
14	Leasehold Improvement			1984	11,510		Various			11,510	14
15	Leasehold Improvement			1985	70,113		Various			70,133	15
16	Leasehold Improvement			1986	7,764	16	Various	204	188	6,645	16
17	Leasehold Improvement			1988	2,015	64	Various	66	2	1,469	17
18	Leasehold Improvement			1990	2,480		Various			2,480	18
19	Leasehold Improvement			1991	23,204	684	Various	781	97	14,920	19
20	Leasehold Improvement			1992	45,806	1455	Various	1,504	49	28,286	20
21	Leasehold Improvement			1993	11,951	364	Various	374	10	6,422	21
22	Leasehold Improvement			1995	4,939	62	Various	62		4,666	22
23	Leasehold Improvement			1996	6,289		Various			6,289	23
24	Leasehold Improvement			1997	63,654	2,132	Various	2,132		28,305	24
25	Leasehold Improvement			1998	45,605	1169	Various	1,144	(25)	13,799	25
26	Leasehold Improvement			1999	2,066	53	Various	53		607	26
27	Leasehold Improvement			2000	4,528	116	10	453	337	4,302	27
28											28
29	Shower faucets			2000	1,550	40	10	155	115	1,473	29
30	Door locks			2001	1,500		10	150	150	1,275	30
31	Water heater			2002	4,283	116	10	428	312	3,354	31
32	New roof			2004	28,437	729	39	711	(18)	4,621	32
33	Flooring			2005	5,323	136	39	136		708	33
34	Tiling in Showers			2005	1,062	27	39	27		136	34
35	Sprinkler			2006	860	22	39	12	(10)	60	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/01/09 Ending: 09/30/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Fire alarm system	2007	$ 42,256	$ 1,084	40	$ 1,057	$ (27)	$ 3,836	37
38	Water line	2007	7,175	184	40	179	(5)	627	38
39	Concrete work for entrance and walkways	2007	64,272		20	1,606	1,606	6,425	39
40	Parking lot blacktop & striping	2007	33,585		20	1,680	1,680	5,880	40
41	Manor landscaping improvements	2007	10,560		20	525	525	1,839	41
42	Roof repairs	2006	3,250		20	163	163	590	42
43									43
44	Toilets & installation	2008	15,426	2,698	20	771	(1,927)	1,928	44
45	New railings	2008	6,315	162	20	316	154	790	45
46	Iron fence	2008	4,895	419	20	245	(174)	612	46
47	Major landscaping	2008	11,721		20	586	586	1,465	47
48									48
49	Sewer cable machine	2009	2,899		10	290	290	435	49
50	Water heater	2009	5,998	154	40	150	(4)	225	50
51	Air conditioner-10 Ton	2009	9,995		40	250	250	375	51
52	6 Heating / cooling units	2009	3,356		10	336	336	504	52
53	Water heater	2009	5,140	132	40	128	(4)	192	53
54									54
55									55
56	Sprinkler System	2010	50,884	59	20	1,272	1,213	1,272	56
57	Nurse Call System	2010	48,241	48,241	20	1,206	(47,035)	1,206	57
58									58
59	Unreconciled book depreciation			(41,349)			41,349		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)		$ 1,649,119	$ 18,969		$ 35,119	$ 16,150	$ 1,150,530	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/01/09 Ending: 09/30/10

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	$ 117,250	$ 562	$ 10,138	$ 9,576	3-40 Yrs	$ 66,917	71
72	Current Year Purchases	13,960	13,960	1,397	(12,563)	5	1,397	72
73	Fully Depreciated Assets	630,552					630,552	73
74								74
75	TOTALS	$ 761,762	$ 14,522	$ 11,535	$ (2,987)		$ 698,866	75

D. Vehicle Depreciation (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	$	$	$	4	$ 44,983	76
77										77
78										78
79										79
80	TOTALS			$ 44,983	$	$	$		$ 44,983	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)	$ 2,490,468	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 33,491	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 46,654	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 13,163	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,894,379	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	N/A				87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93		N/A	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' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/01/09 Ending: 09/30/10

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:				$ N/A			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

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

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

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

	Fiscal Year Ending	Annual Rent
12.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ 2,363 Description: Oxygen - $2,363
(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			N/A		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' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/01/09 Ending: 09/30/10

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [ ] YES [X] NO

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

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/01/09 Ending: 09/30/10

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

	1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10A, C3	hrs	$	1,677	$	120,721	$	1,677	$ 120,721	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		47		3,380		47	3,380	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	L10A, C3	hrs		2,062		148,467		2,062	148,467	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					52,291		52,291	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Other (specify):										12
13	Other (specify): Other Medical Services	L39 C3					143			143	13
14	TOTAL			$	3,786	$	272,711	$ 52,291	3,786	$ 325,002	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' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Home # 0021428 **Report Period Beginning:** 10/01/09 **Ending:** 09/30/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 09/30/10 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 173,825	$ 173,825	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance Zero)	256,867	256,867	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	252,065	252,065	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	95,211	95,211	8
9	Other(specify): See Schedule 17A	4,380	4,380	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 782,348	$ 782,348	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	2,024	2,024	12
13	Land	34,604	34,604	13
14	Buildings, at Historical Cost	1,004,253	973,138	14
15	Leasehold Improvements, at Historical Cost	552,419	675,981	15
16	Equipment, at Historical Cost	886,934	806,745	16
17	Accumulated Depreciation (book methods)	(1,929,897)	(1,894,379)	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): §444 Election Deposit	4,809	4,809	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 555,146	$ 602,922	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,337,494	$ 1,385,270	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 120,283	$ 120,283	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	35,437	35,437	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	21,705	21,705	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Current Liabilities	9,326	9,326	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 186,751	$ 186,751	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)**	$ 186,751	$ 186,751	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,150,743	$ 1,198,519	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,337,494	$ 1,385,270	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Walker Nursing Home
Facility ID#: 0021428
Year 9/30/2010 Schedule 17A

Line 9 - Other Current Assets

	Operating	After Consolidation
Income Tax Refund Receivable	683	683
Employee Advances	340	340
Advances - Other	2,640	2,640
FICA Withholding	717	717
	4,380	4,380

Line 36 - Other Current Liabilities

Christmas Club Withholding	6,690	6,690
State Unemployment Payable	2,222	2,222
Federal Unemployment Payable	414	414
	9,326	9,326

See Accountant's Compliation Report

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/01/09 Ending: 09/30/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,072,783	1
2	Restatements (describe):		2
3	**Prior Period Adjustment**	(72,097)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,000,686	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	114,689	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	35,368	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)**	$ 150,057	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)**	$ 1,150,743	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/01/09 Ending: 09/30/10

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,451,445	1
2	Discounts and Allowances for all Levels	(9,980)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,441,465	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,436	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,436	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Revenue	11,998	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 11,998	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,457,899	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	500,949	31
32	Health Care	1,139,486	32
33	General Administration	481,840	33
	B. Capital Expense		
34	Ownership	60,404	34
	C. Ancillary Expense		
35	Special Cost Centers	121,658	35
36	Provider Participation Fee	38,873	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,343,210	40
41	**Income before Income Taxes (line 30 minus line 40)****	114,689	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 114,689	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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. SEE ACCOUNTANTS' COMPILATION REPORT**

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

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/01/09 Ending: 09/30/10

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	867	878	$ 20,340	$ 23.17	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,235	4,342	109,826	25.29	3
4	Licensed Practical Nurses	15,786	16,285	305,678	18.77	4
5	CNAs & Orderlies	31,764	32,688	325,315	9.95	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,067	2,107	20,496	9.73	9
10	Activity Assistants					10
11	Social Service Workers	2,269	2,348	33,664	14.34	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,106	2,149	26,979	12.55	14
15	Cook Helpers/Assistants	10,990	11,363	95,537	8.41	15
16	Dishwashers					16
17	Maintenance Workers	452	460	20,468	44.47	17
18	Housekeepers	5,578	5,696	48,162	8.46	18
19	Laundry	5,210	5,353	47,218	8.82	19
20	Administrator	1,767	1,815	33,547	18.49	20
21	Assistant Administrator	3,478	3,573	71,612	20.04	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,133	3,219	50,945	15.83	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)	89,702	92,275	$ 1,209,787 *	$ 13.11	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	416	$ 5,376	1(3)	35
36	Medical Director	Monthly	3,685	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					47
48					48
49	TOTAL (lines 35 - 48)	416	$ 14,161		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/01/09 Ending: 09/30/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
George W. White	Co-Administrator	50	$ 16,747
Mary Ann White	Co-Administrator	50	16,800
Bryan White	Asst. Administrator	0	35,793
Rachel White	Asst. Administrator	0	35,819
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 105,159

B. Administrative - Other

Description	Amount
N/A	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
RSM/M&P	Accounting	$ 36,665
CSC	Legal Services	356
Cavanaugh & O'Hara	Legal Services	14,601
IKON	Financial Services	55
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 51,677

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 40,051
Unemployment Compensation Insurance	15,548
FICA Taxes	91,053
Employee Health Insurance	25,626
Employee Meals	359
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	12,734
TOTAL (agree to Schedule V, line 22, col.8)	$ 185,371

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 928
Advertising: Employee Recruitment	1,759
Health Care Worker Background Check	
(Indicate # of checks performed 38)	450
Patient Background Checks 42	500
Illinois Nursing Home Admin. Assn.	490
Other Subscriptions & Licenses	70
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,197

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
See Schedule 21A	4,748
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,748

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Walker Nursing Home
FYE 9/30/10
Schedule 21A

Pg 21C - Professional Services

Professional Services per Page 19 Section C	51,677
Less : Disallowed Legal Expense	(14,601)
Total agreeing with P3, L19, C8	37,076

PG21G - Travel and Seminar

Area Agency on Aging	$12.00
Barnes & Nobles	$31.01
Corporate Training Course	$120.00
Danny Davidson	$325.00
Hampton Inn	$110.88
IHCA	$550.00
IL Health Care Assoc	$360.00
IL Nursing Home Assn	$625.00
INHAA	$375.00
L.L.C.C,	$600.00
Lincoln Land Comm College	$1,343.06
Royal Publishing	$100.00
Standby Power Solutions	$135.00
WPS Medicare	$61.00
Total	$4,747.95

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/01/09 Ending: 09/30/10

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		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Home # 0021428 **Report Period Beginning:** 10/01/09 **Ending:** 09/30/10

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **IL Nursing Home Admin Assn - $490**

(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? **5 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line **10(2)**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **38,873**
This amount is to be recorded on line 42 of Schedule V.

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **359** 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) 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? **No**
Attach invoices and a summary of services for all architect and appraisal fees.