

Facility Name & ID Number Walker Nursing Home

0021428 Report Period Beginning: 10/01/05 Ending: 09/30/06

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>71</u>	Skilled (SNF)	<u>71</u>	<u>25,915</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>25,915</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other		5 Total
8	SNF	<u>356</u>	<u>504</u>	<u>417</u>	<u>1,277</u>	8
9	SNF/PED					9
10	ICF	<u>9,277</u>	<u>6,067</u>		<u>15,344</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>9,633</u>	<u>6,571</u>	<u>417</u>	<u>16,621</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.14%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 01/01/1955

J. Was the facility purchased or leased after January 1, 1978?
YES Date N/A 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 417

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 09/30/06 Fiscal Year: 09/30/06

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

SEE INDEPENDENT ACCOUNTANT'S REPORT

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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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	111,795	625	5,376	117,796		117,796		117,796		1
2	Food Purchase		124,533		124,533		124,533	(341)	124,192		2
3	Housekeeping	56,072	1,784		57,856		57,856		57,856		3
4	Laundry	26,720	69	989	27,778		27,778		27,778		4
5	Heat and Other Utilities			68,684	68,684		68,684		68,684		5
6	Maintenance	24,327	2,742	28,793	55,862		55,862		55,862		6
7	Other (specify):*										7
8	TOTAL General Services	218,914	129,753	103,842	452,509		452,509	(341)	452,168		8
	B. Health Care and Programs										
9	Medical Director			1,600	1,600		1,600		1,600		9
10	Nursing and Medical Records	666,158	17,464	526	684,148		684,148		684,148		10
10a	Therapy			57,274	57,274		57,274		57,274		10a
11	Activities	22,374	2,490	675	25,539		25,539		25,539		11
12	Social Services	24,769		5,100	29,869		29,869		29,869		12
13	CNA Training										13
14	Program Transportation			934	934		934		934		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	713,301	19,954	66,109	799,364		799,364		799,364		16
	C. General Administration										
17	Administrative	92,340			92,340		92,340		92,340		17
18	Directors Fees										18
19	Professional Services			54,239	54,239		54,239	(1,187)	53,052		19
20	Dues, Fees, Subscriptions & Promotions			11,677	11,677		11,677		11,677		20
21	Clerical & General Office Expenses	39,360	9,388	6,964	55,712		55,712		55,712		21
22	Employee Benefits & Payroll Taxes			158,823	158,823		158,823	341	159,164		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,456	1,456		1,456		1,456		24
25	Other Admin. Staff Transportation			6,852	6,852		6,852	(1,557)	5,295		25
26	Insurance-Prop.Liab.Malpractice			35,505	35,505		35,505		35,505		26
27	Other (specify):*										27
28	TOTAL General Administration	131,700	9,388	275,516	416,604		416,604	(2,403)	414,201		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,063,915	159,095	445,467	1,668,477		1,668,477	(2,744)	1,665,733		29

SEE INDEPENDENT ACCOUNTANT'S REPORT

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

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

**See schedule of adjustments attached at end of cost report.

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			35,131	35,131		35,131	33,063	68,194			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			26,600	26,600		26,600		26,600			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			714	714		714		714			35
36	Other (specify):*											36
37	TOTAL Ownership			62,445	62,445		62,445	33,063	95,508			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		12,774		12,774		12,774		12,774			39
40	Barber and Beauty Shops			124	124		124		124			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			39,150	39,150		39,150		39,150			42
43	Other (specify):* Nonallowable Cost			8,736	8,736		8,736	(8,736)				43
44	TOTAL Special Cost Centers		12,774	48,010	60,784		60,784	(8,736)	52,048			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,063,915	171,869	555,922	1,791,706		1,791,706	21,583	1,813,289			45

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

**See schedule of adjustments attached at end of cost report.

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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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF 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	33,063	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	(566)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(1,557)	25		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(201)	43		18
19	Entertainment	(1,468)	43		19
20	Contributions	(962)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(4,247)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,292)	43		28
29	Other-Attach Schedule Legal Fees	(1,187)	19		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 21,583		\$	30

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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 21,583		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	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY					
48	49	50	51	52	

SEE INDEPENDENT ACCOUNTANT'S REPORT

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 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 NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V			N/A				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.

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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	Mary Ann White	President	Co-Administrator	50.00	0	20	40.00	Salary	\$ 16,800	17(1)	1
2			Office Manager			30	60.00	Salary	25,200	21(1)	2
3											3
4	George W. White	Vice-President	Co-Administrator	50.00	0	22.5	45.00	Salary	18,900	17(1)	4
5			Maintenance			27.5	55.00	Salary	23,100	6(1)	5
6											6
7	Bryan White	None	Asst. Admin	0.00	0	32	80.00	Salary	28,800	17(1)	7
8			Clerical			8	20.00	Salary	7,200	21(1)	8
9											9
10	Rachel White	None	Asst. Admin	0.00	0	32	80.00	Salary	27,840	17(1)	10
11			Clerical			8	20.00	Salary	6,960	21(1)	11
12											12
13								TOTAL	\$ 154,800		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

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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

Name of Related Organization

N/A

Street Address

City / State / Zip Code

Phone Number

()

Fax Number

()

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

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

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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	Name of Lender	2		3	4	5	6		7	8	9	10						
		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				N/A								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. \$ None 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.)

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

(See instructions.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 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 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>09-033-009-00</u>	<u>Lot</u>	\$ <u>1,055.04</u>	\$ <u>1,055.04</u>
2. <u>11-052-009-00</u>	<u>Lot</u>	\$ <u>777.64</u>	\$ <u>777.64</u>
3. <u>11-064-010-01</u>	<u>Lot</u>	\$ <u>1,824.40</u>	\$ <u>1,824.40</u>
4. <u>11-087-007-00</u>	<u>Lot</u>	\$ <u>23,196.94</u>	\$ <u>23,196.94</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>26,854.02</u>	\$ <u>26,854.02</u>

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 & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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.

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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? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident care</u>	<u>22,176</u>	<u>1955</u>	<u>\$ 11,000</u>	<u>1</u>
2	<u>Resident care</u>	<u>9,504</u>	<u>1981</u>	<u>23,604</u>	<u>2</u>
3	TOTALS	31,680		\$ 34,604	3

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	20	1972	1972	\$ 130,523	\$	30	\$	\$	\$ 130,523	4
5	30	1977	1977	363,607		30	12,120	12,120	351,481	5
6	5	1981	1981	79,226		30	2,641	2,641	67,955	6
7	16	1985	1985	399,762		30	13,326	13,326	279,842	7
8										8
	Improvement Type**									
9										9
10	Leasehold Improvements		1974	900		Various			900	10
11	Leasehold Improvements		1975	200		Various			200	11
12	Leasehold Improvements		1977	2,889		Various	23	23	2,867	12
13	Leasehold Improvements		1982	552		Various			552	13
14	Leasehold Improvements		1983	533		Various			533	14
15	Leasehold Improvements		1984	11,510		Various			11,510	15
16	Leasehold Improvements		1985	70,113		Various	12	12	70,060	16
17	Leasehold Improvements		1986	7,764	16	Various	204	188	5,829	17
18	Leasehold Improvements		1988	2,015	64	Various	66	2	1,205	18
19	Leasehold Improvements		1990	2,480		Various			2,477	19
20	Leasehold Improvements		1991	23,204	684	Various	781	97	11,796	20
21	Leasehold Improvements		1992	45,806	1,455	Various	1,504	49	22,270	21
22	Leasehold Improvements		1993	11,951	364	Various	374	10	4,926	22
23	Leasehold Improvements		1995	4,939	62	Various	62		4,418	23
24	Leasehold Improvements		1996	6,289		Various	185	185	6,130	24
25	Leasehold Improvements		1997	63,654	2,132	Various	2,132		19,777	25
26	Leasehold Improvements		1998	45,605	1,169	Various	1,144	(25)	9,223	26
27	Leasehold Improvements		1999	2,066	53	Various	53		395	27
28	Leasehold Improvements		2000	4,528	113	10	453	340	2,490	28
29										29
30	Detail improvements for the years 2001-2006									
31	Shower Faucets		2000	1,550	39	10	155	116	853	31
32	Door Locks		2001	1,500	150	10	150		675	32
33	Water Heater		2002	4,283	107	10	428	321	1,642	33
34	New Roof		2004	28,437	711	10	711		1,777	34
35	Flooring		2005	5,323	133	39	136	3	164	35
36	Tiling in Showers		2005	1,062	27	39	27		28	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 INDEPENDENT ACCOUNTANTS' REPORT

Facility Name & ID Number Walker Nursing Home

0021428

Report Period Beginning:

10/01/05

Ending:

09/30/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 Sprinkler	2006	\$ 860	\$ 13	39	\$ 12	\$ (1)	\$ 12	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 1,323,131	\$ 7,292		\$ 36,699	\$ 29,407	\$ 1,012,510	70

SEE INDEPENDENT ACCOUNTANTS' REPORT

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

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	\$ 708,336	\$ 15,451	\$ 22,288	\$ 6,837	3-39	\$ 620,866	71
72	Current Year Purchases	24,951	1,616	3,413	1,797	3-7	3,413	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 733,287	\$ 17,067	\$ 25,701	\$ 8,634		\$ 624,279	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	\$ 8,997	\$ 5,794	\$ (3,203)	4	\$ 44,955	76
77										77
78										78
79										79
80	TOTALS			\$ 44,983	\$ 8,997	\$ 5,794	\$ (3,203)		\$ 44,955	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)	\$ 2,136,005	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 33,356	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 68,194	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 34,838	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,681,744	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	1996 Dodge Ram	\$ 33,608	\$ 1,775	\$ 33,608	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 33,608	\$ 1,775	\$ 33,608	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 INDEPENDENT ACCOUNTANTS' 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:				\$ <u>N/A</u>			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: \$ 714 Description: Dishwasher - 714

(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			<u>N/A</u>		18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2007 \$ _____

13. _____ /2008 \$ _____

14. _____ /2009 \$ _____

* 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 INDEPENDENT ACCOUNTANTS' REPORT

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>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.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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 INDEPENDENT ACCOUNTANTS' REPORT**

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

	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	\$	531	\$ 26,500	\$	531	\$ 26,500	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		15	700		15	700	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		581	29,000		581	29,000	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				12,774		12,774	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	1,127	\$ 56,200	\$ 12,774	1,127	\$ 68,974	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 INDEPENDENT ACCOUNTANTS' REPORT

Facility Name & ID Number Walker Nursing Home
 XV. BALANCE SHEET - Unrestricted Operating Fund.

0021428
 As of 09/30/06

Report Period Beginning: 10/01/05
 (last day of reporting year)

Ending: 09/30/06

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	\$ 71,114	\$ 71,114	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance -0-)	218,397	218,397	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	354,352	354,352	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	60,837	60,837	8
9	Other(specify): See Schedule 17A	1,312	1,312	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 706,012	\$ 706,012	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	1,030,309	1,030,309	14
15	Leasehold Improvements, at Historical Cost	292,822	292,822	15
16	Equipment, at Historical Cost	811,878	811,878	16
17	Accumulated Depreciation (book methods)	(1,822,133)	(1,715,352)	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): Sec, 444 election deposit	14,040	14,040	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 363,544	\$ 470,325	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,069,556	\$ 1,176,337	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 24,234	\$ 24,234	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	12,281	12,281	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	20,610	20,610	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	2,036	2,036	35
	Other Current Liabilities(specify):			
36	Payroll related withholding	16,693	16,693	36
37	Due to Shareholder	2,000	2,000	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 77,854	\$ 77,854	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)	\$ 77,854	\$ 77,854	46
47	TOTAL EQUITY(page 18, line 24)	\$ 991,702	\$ 1,098,483	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,069,556	\$ 1,176,337	48

Walker Nursing Home
Facility ID # 0021428
10/1/2005 to 9/30/2006

17A

Line 9 - Other Current Assets

Refundable overpayment on sales tax	1,062
Employee advance	250
	<u>1,312</u>
	<u><u>1,312</u></u>

SEE INDEPENDENT ACCOUNTANTS' REPORT

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 971,783	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 971,783	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	107,755	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	(87,836)	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)	\$ 19,919	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)	\$ 991,702	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE INDEPENDENT ACCOUNTANTS' REPORT

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

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 1,907,120	1
2	Discounts and Allowances for all Levels	(25,333)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,881,787	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	4,945	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)	\$ 4,945	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	12,729	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 12,729	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,899,461	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	452,509	31
32	Health Care	799,364	32
33	General Administration	416,604	33
	B. Capital Expense		
34	Ownership	62,445	34
	C. Ancillary Expense		
35	Special Cost Centers	21,634	35
36	Provider Participation Fee	39,150	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,791,706	40
41	Income before Income Taxes (line 30 minus line 40)**	107,755	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 107,755	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No 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 INDEPENDENT ACCOUNTANTS' REPORT

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

Facility Name & ID Number Walker Nursing Home

0021428

Report Period Beginning:

10/01/05

Ending:

09/30/06

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	2,226	2,257	\$ 60,241	\$ 26.69	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,239	2,265	48,348	21.35	3
4	Licensed Practical Nurses	16,331	16,540	275,591	16.66	4
5	CNAs & Orderlies	31,131	31,544	281,978	8.94	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,900	1,926	17,464	9.07	9
10	Activity Assistants	724	736	4,910	6.67	10
11	Social Service Workers	1,938	1,965	24,769	12.61	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,785	2,820	28,556	10.13	14
15	Cook Helpers/Assistants	10,401	10,533	83,239	7.90	15
16	Dishwashers					16
17	Maintenance Workers	1,274	1,303	24,327	18.67	17
18	Housekeepers	7,418	7,534	56,072	7.44	18
19	Laundry	3,227	3,271	26,720	8.17	19
20	Administrator	1,773	1,797	35,700	19.87	20
21	Assistant Administrator	3,338	3,383	56,640	16.74	21
22	Other Administrative					22
23	Office Manager	1,252	1,268	25,200	19.87	23
24	Clerical	834	845	14,160	16.76	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)	88,791	89,987	\$ 1,063,915 *	\$ 11.82	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	192	\$ 5,376	1(3)	35
36	Medical Director	16	1,600	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	10	500	10A(3)	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	11	574	10A(3)	43
44	Activity Consultant	27	675	11(3)	44
45	Social Service Consultant	monthly	5,100	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	256	\$ 13,825		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	28	526		52
53	TOTAL (lines 50 - 52)	28	\$ 526		53

SEE INDEPENDENT ACCOUNTANTS' REPORT

Facility Name & ID Number Walker Nursing Home

0021428

Report Period Beginning: 10/01/05

Ending: 09/30/06

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	
George W. White	Co-Administrator	50	\$ 18,900	Workers' Compensation Insurance	\$ 27,786	IDPH License Fee	\$	
Mary Ann White	Co-Administrator	50	16,800	Unemployment Compensation Insurance	12,304	Advertising: Employee Recruitment	7,507	
Bryan White	Asst. Administrator	0	28,800	FICA Taxes	79,369	Health Care Worker Background Check		
Rachel White	Asst. Administrator	0	27,840	Employee Health Insurance	36,272	(Indicate # of checks performed 15)	100	
				Employee Meals	341	Patient Background Checks	52	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Subscriptions	358	
				Other Employee Insurance	2,802	Illinois Health Care Assn dues	2,188	
				Other Employee Benefits	290	Miscellaneous Licenses	1,174	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 92,340					
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				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
McGladrey & Pullen	Accounting		\$ 39,963				Out-of-State Travel	\$
Metnick, Cherry, Frazier	Legal		2,721					
Brown, Hay & Stephens	Legal		1,051	N/A				
Accu-Med	Software consultation		9,350				In-State Travel	
Enloe Pharmacy	Software consultation		900					
Corporation Service	Administrative consulting		254				Seminar Expense	1,456
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			Entertainment Expense	()
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 54,239				(agree to Sch. V,	
							line 24, col. 8)	\$ 1,456

* Attach copy of IMRF notifications
SEE INDEPENDENT ACCOUNTANTS' REPORT

**See instructions.

Professional Services

Vendor/Payee	Amount	
Metnick, Cherry, Frazier	2,721	
	(136)	Out of period expense
	<u>2,585</u>	Adjusted balance
Brown, Hay & Stephens	1,051	
	(1,051)	Out of period expense
	<u>-</u>	Adjusted balance
McGladrey & Pullen	39,963	
	<u>39,963</u>	
Accu-Med	9,350	
	<u>9,350</u>	
Enloe Pharmacy	900	
	<u>900</u>	
Corporation Service	254	
	<u>254</u>	
	<u>53,052</u>	

TOTAL (agree to Schedule V, line 19, column 3)

SEE INDEPENDENT ACCOUNTANTS' REPORT

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								
					FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7					N/A								
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE INDEPENDENT ACCOUNTANTS' REPORT

Facility Name & ID Number Walker Nursing Home

0021428

Report Period Beginning:

10/01/05

Ending:

09/30/06

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Health Care Association - 2,188
- (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. \$ 726 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. \$ 39,150
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. \$ 341 Has any meal income been offset against related costs? N/A 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? 100%
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 The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. 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 \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees

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