

Facility Name & ID Number Walker Nursing Home

0021428 Report Period Beginning: 10/01/2007 Ending: 09/30/08

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF		<u>366</u>	<u>1,745</u>	<u>2,111</u>	8
9	SNF/PED					9
10	ICF	<u>7,720</u>	<u>5,649</u>		<u>13,369</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>7,720</u>	<u>6,015</u>	<u>1,745</u>	<u>15,480</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.57%

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 NO Note: Non-allowable costs have been eliminated in Schedule V, Column 7.

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

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

J. Was the facility purchased or leased after January 1, 1978?
YES Date 01/01/1955 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 1,745

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 09/30/08 Fiscal Year: 09/30/08

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

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/01/2007 Ending: 09/30/08

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	123,093	689	4,928	128,710		128,710		128,710		1
2	Food Purchase		117,430		117,430		117,430		117,430		2
3	Housekeeping	50,489	7,282		57,771		57,771		57,771		3
4	Laundry	38,629	5,872	749	45,250		45,250		45,250		4
5	Heat and Other Utilities			73,684	73,684		73,684		73,684		5
6	Maintenance	23,841	5,499	36,409	65,749		65,749	4,267	70,016		6
7	Other (specify):*										7
8	TOTAL General Services	236,052	136,772	115,770	488,594		488,594	4,267	492,861		8
	B. Health Care and Programs										
9	Medical Director			2,400	2,400		2,400		2,400		9
10	Nursing and Medical Records	727,502	43,635	437	771,574		771,574		771,574		10
10a	Therapy			184,617	184,617		184,617		184,617		10a
11	Activities	18,967	1,668	5,100	25,735		25,735		25,735		11
12	Social Services	30,052			30,052		30,052		30,052		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	776,521	45,303	192,554	1,014,378		1,014,378		1,014,378		16
	C. General Administration										
17	Administrative	98,668			98,668		98,668		98,668		17
18	Directors Fees										18
19	Professional Services			42,360	42,360		42,360		42,360		19
20	Dues, Fees, Subscriptions & Promotions			6,125	6,125		6,125		6,125		20
21	Clerical & General Office Expenses	40,942	9,391	8,283	58,616		58,616		58,616		21
22	Employee Benefits & Payroll Taxes			131,776	131,776		131,776		131,776		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,969	1,969		1,969		1,969		24
25	Other Admin. Staff Transportation			9,996	9,996		9,996		9,996		25
26	Insurance-Prop.Liab.Malpractice			40,518	40,518		40,518		40,518		26
27	Other (specify):*										27
28	TOTAL General Administration	139,610	9,391	241,027	390,028		390,028		390,028		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,152,183	191,466	549,351	1,893,000		1,893,000	4,267	1,897,267		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:

10/01/2007

Ending:

09/30/08

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			38,269	38,269		38,269	9,968	48,237			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			431	431		431	(431)				32
33	Real Estate Taxes			25,800	25,800		25,800	(427)	25,373			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			1,271	1,271		1,271		1,271			35
36	Other (specify):*											36
37	TOTAL Ownership			65,771	65,771		65,771	9,110	74,881			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		65,555	3,288	68,843		68,843		68,843			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			38,175	38,175		38,175		38,175			42
43	Other (specify):* Non-allowable cost			51,122	51,122		51,122	(51,122)				43
44	TOTAL Special Cost Centers		65,555	92,585	158,140		158,140	(51,122)	107,018			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,152,183	257,021	707,707	2,116,911		2,116,911	(37,745)	2,079,166			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.

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	27	43		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	9,968	30		9
10	Interest and Other Investment Income	(431)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(771)	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	(681)	43		19
20	Contributions	(1,952)	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	(2,527)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,194)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(40,184)	var		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (37,745)		\$	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))	\$ (37,745)		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						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

Walker Nursing Home

ID# 0021428

Report Period Beginning: 10/01/2007

Ending: 09/30/08

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Part A Labs	\$ (2,000)	43	1
2	Part A Radiology	(697)	43	2
3	Medicare Services	(32,180)	43	3
4	Promotional Costs	(6,385)	43	4
5	Repair & Maintenance	4,267	6	5
6	Nondeductible Expenses	(352)	43	6
7	Medicare Supplies	(2,410)	43	7
8	Excess Real Estate Tax	(427)	33	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	(40,184)		49

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Walker Nursing Home

0021428

Report Period Beginning:

10/01/2007

Ending:

09/30/08

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	4,267	0	0	0	0	0	0	0	0	0	0	4,267	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	4,267	0	0	0	0	0	0	0	0	0	0	4,267	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	0	0	0	0	0	0	0	0	0	0	0	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	4,267	0	0	0	0	0	0	0	0	0	0	4,267	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Walker Nursing Home

0021428

Report Period Beginning:

10/01/2007

Ending:

09/30/08

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	9,968	0	0	0	0	0	0	0	0	0	0	9,968	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(431)	0	0	0	0	0	0	0	0	0	0	(431)	32
33	Real Estate Taxes	(427)	0	0	0	0	0	0	0	0	0	0	(427)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	9,110	0	9,110	37									
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(51,122)	0	0	0	0	0	0	0	0	0	0	(51,122)	43
44	TOTAL Special Cost Centers	(51,122)	0	(51,122)	44									
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(37,745)	0	(37,745)	45									

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.

Facility Name & ID Number

Walker Nursing Home

0021428

Report Period Beginning:

10/01/2007

Ending:

09/30/08

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	31,785	17(1)	7
8			Clerical			8	20.00	Salary	7,946	21(1)	8
9											9
10	Rachel White	None	Asst. Admin	0.00	0	32	80.00	Salary	31,183	17(1)	10
11			Clerical			8	20.00	Salary	7,796	21(1)	11
12											12
13								TOTAL	\$ 162,710		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: 10/01/2007

Ending: 09/30/08

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 _____

Street Address N/A

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									4
5			N/A						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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Walker Nursing Home COUNTY Cass

FACILITY IDPH LICENSE NUMBER 0021428

CONTACT PERSON REGARDING THIS REPORT Mary Ann White

TELEPHONE (217) 452-3218 FAX #: (217) 452-7746

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(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>Nursing Home Facility</u>	\$ <u>451.14</u>	\$ <u>451.14</u>
2. <u>11-052-009-00</u>	<u>Nursing Home Facility</u>	\$ <u>634.44</u>	\$ <u>634.44</u>
3. <u>11-187-007-00</u>	<u>Nursing Home Facility</u>	\$ <u>23,682.82</u>	\$ <u>23,682.82</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>24,768.40</u>	\$ <u>24,768.40</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Home

0021428

Report Period Beginning:

10/01/2007 Ending:

09/30/08

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

None

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Home

0021428

Report Period Beginning:

10/01/2007

Ending:

09/30/08

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			363,607	5
6	5	1981	1981	79,226		30	2,641	2,641	73,237	6
7	16	1985	1985	399,782		30	13,326	13,326	306,494	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	61	61	70,133	15
16	Leasehold Improvement		1986	7,764	16	Various	204	188	6,237	16
17	Leasehold Improvement		1988	2,015	64	Various	66	2	1,337	17
18	Leasehold Improvement		1990	2,480		Various	3	3	2,480	18
19	Leasehold Improvement		1991	23,204	684	Various	781	97	13,358	19
20	Leasehold Improvement		1992	45,806	1,455	Various	1,504	49	25,278	20
21	Leasehold Improvement		1993	11,951	364	Various	374	10	5,674	21
22	Leasehold Improvement		1995	4,939	62	Various	62		4,542	22
23	Leasehold Improvement		1996	6,289		Various	159	159	6,289	23
24	Leasehold Improvement		1997	63,654	2,132	Various	2,132		24,041	24
25	Leasehold Improvement		1998	45,605	1,169	Various	1,144	(25)	11,511	25
26	Leasehold Improvement		1999	2,066	53	Various	53		501	26
27	Leasehold Improvement		2000	4,528	113	10	453	340	3,396	27
28										28
29	Shower faucets		2000	1,550	39	10	155	116	1,163	29
30	Door locks		2001	1,500	150	10	150		975	30
31	Water heater		2002	4,283	107	10	428	321	2,498	31
32	New roof		2004	28,437	711	39	711		3,199	32
33	Flooring		2005	5,323	133	39	136	3	436	33
34	Tiling in Showers		2005	1,062	27	39	27		82	34
35	Sprinkler		2006	860	13	39	12	(1)	36	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

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Fire alarm system	2007	\$ 42,256	\$ 529	40	\$ 1,057	\$ 528	\$ 1,722	37
38	Water line	2007	7,175	15	40	179	164	269	38
39	Concrete work for entrance and walkways	2007	64,272	536	20	1,606	1,070	3,213	39
40	Parking lot blacktop & striping	2007	33,585	280	20	1,680	1,400	2,520	40
41	Manor landscaping improvements	2007	10,560	44	20	525	481	789	41
42	Roof repairs	2006	3,250		20	163	163	264	42
43									43
44	Toilets & installation	2008	15,426	386	20	386		386	44
45	New railings	2008	6,315	158	20	158		158	45
46	Iron fence	2008	4,895	122	20	122		122	46
47	Major landscaping	2008	11,721	293	20	293		293	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)		\$ 1,522,606	\$ 9,655		\$ 30,751	\$ 21,096	\$ 1,083,347	70

SEE ACCOUNTANTS' COMPILATION 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	\$ 743,620	\$ 28,614	\$ 17,486	\$ (11,128)	3-39	\$ 671,398	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 743,620	\$ 28,614	\$ 17,486	\$ (11,128)		\$ 671,398	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)	\$ 2,345,813	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 38,269	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 48,237	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 9,968	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,799,728	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	\$	\$ 33,608	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 33,608	\$	\$ 33,608	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	92
93			93
94			94
95		\$	95

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

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

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: \$ 1,271 Description: Dishwasher - 828; Misc maintenance rentals - 443

(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

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. _____ /2009 \$ _____

13. _____ /2010 \$ _____

14. _____ /2011 \$ _____

* 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.

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?</p> <p><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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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 ACCOUNTANTS' COMPILATION 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	10A(3)	hrs	\$	952	\$ 57,134	\$	952	\$ 57,134	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		111	6,667		111	6,667	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		2,014	120,816		2,014	120,816	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				65,555		65,555	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	39(3)				3,288			3,288	13
14	TOTAL			\$	3,077	\$ 187,905	\$ 65,555	3,077	\$ 253,460	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

Walker Nursing Home

Facility ID#: 0021428

Year 09/30/08

Schedule 17A

Line 9 - Other Current Assets

Income Tax Refund Receivable	56
Refundable Overpayment on Sales Tax	327
Employee Advances	340
Advances - Other	2,640
	<u>3,363</u>
	<u><u>3,363</u></u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 995,187	1
2	Restatements (describe):		2
3	Unlocated variance	(457)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 994,730	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	24,131	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(13,100)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Rounding	(1)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 11,030	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)	\$ 1,005,760	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION 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	\$ 2,138,114	1
2	Discounts and Allowances for all Levels	(11,447)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,126,667	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	1,695	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)	\$ 1,695	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	9,733	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 9,733	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Schedule 19A</u>	2,947	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,947	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,141,042	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	488,594	31
32	Health Care	1,014,378	32
33	General Administration	390,028	33
	B. Capital Expense		
34	Ownership	65,771	34
	C. Ancillary Expense		
35	Special Cost Centers	119,965	35
36	Provider Participation Fee	38,175	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,116,911	40
41	Income before Income Taxes (line 30 minus line 40)**	24,131	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 24,131	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. Facility files S-corporation tax return.

*** 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.

Walker Nursing Home

Facility ID#: 0021428

Year 09/30/08

Schedule 19A

Line 28 - Other Revenue (specify)

Dividends	2,312
Long & Short Term Capital Gains/Loss	2,317
Miscellaneous Revenue	6,913
Gain/Loss on Sale of Assets	19
Unrealized Gains/Loss on Investments	(8,614)
	<u>2,947</u>
	<u><u>2,947</u></u>

Facility Name & ID Number Walker Nursing Home

0021428

Report Period Beginning: 10/01/2007

Ending: 09/30/08

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	2,497	2,542	\$ 77,130	\$ 30.34	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,129	2,167	45,818	21.14	3
4	Licensed Practical Nurses	16,031	16,292	304,967	18.72	4
5	CNAs & Orderlies	30,510	31,119	299,587	9.63	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,947	1,985	18,967	9.56	9
10	Activity Assistants					10
11	Social Service Workers	2,105	2,141	30,052	14.04	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,810	2,855	32,016	11.21	14
15	Cook Helpers/Assistants	10,260	10,426	91,077	8.74	15
16	Dishwashers					16
17	Maintenance Workers	1,228	1,250	23,841	19.07	17
18	Housekeepers	6,097	6,244	50,489	8.09	18
19	Laundry	4,436	4,526	38,629	8.53	19
20	Administrator	1,778	1,812	35,700	19.70	20
21	Assistant Administrator	3,346	3,410	62,968	18.47	21
22	Other Administrative					22
23	Office Manager	1,255	1,279	25,200	19.70	23
24	Clerical	837	853	15,742	18.45	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)	87,266	88,901	\$ 1,152,183 *	\$ 12.96	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	190	\$ 4,928	1(3)	35
36	Medical Director	Monthly	2,400	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)	190	\$ 12,428		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	23	437	10(3)	52
53	TOTAL (lines 50 - 52)	23	\$ 437		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Home

0021428

Report Period Beginning: 10/01/2007

Ending: 09/30/08

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	Administrator	50	\$ 18,900	Workers' Compensation Insurance	\$ 23,901	IDPH License Fee	\$	
Mary Ann White	Administrator	50	16,800	Unemployment Compensation Insurance	9,861	Advertising: Employee Recruitment	4,052	
Bruan White	Asst. Admin	0	31,785	FICA Taxes	86,924	Health Care Worker Background Check		
Rachel White	Asst. Admin	0	31,183	Employee Health Insurance	10,395	(Indicate # of checks performed 9)	138	
				Employee Meals		Patient Background Checks	27 412	
				Illinois Municipal Retirement Fund (IMRF)*		Illinois Nursing Home Admin. Assn.	360	
				Other Employee Benefits	695	Other Subscriptions and Licenses	1,163	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 98,668					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)				
Description			Amount			Less: Public Relations Expense	()	
N/A			\$			Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$			TOTAL (agree to Sch. V, line 20, col. 8)	\$ 6,125	
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description			Description	
Vendor/Payee	Type		Amount		Line #	Amount		Amount
Chris Perrin	Legal		\$ 53				Out-of-State Travel	\$
Longrigan, Potter & Randle	Legal		4,254					
Metnick, Cherry, Frazier, Sabin	Legal		52	N/A			In-State Travel	
Scott & Scott	Legal		596					
McGladrey & Pullen, LLP	Accounting		28,008				Seminar Expense	1,969
RSM McGladrey, Inc.	Accounting		8,025					
Computer Concepts	Computer Services		472				Entertainment Expense	()
Enloe Pharmacy	Software Services		900				(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 1,969
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$		
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 42,360					

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4		N/A											
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: 10/01/2007

Ending: 09/30/08

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. N/A
- (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? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,679 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. \$ 38,175
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 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? No
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? 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. N/A
- 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 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 \$5,000, 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