



Facility Name & ID Number Walker Nursing Home

# 0021428 Report Period Beginning: 10/1/08 Ending: 9/30/09

**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	71	Skilled (SNF)	71	25,915	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	71	TOTALS	71	25,915	7

B. Census-For the entire report period.

	1 Level of Care	2 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	273	92	1,459	1,824	8
9	SNF/PED					9
10	ICF	9,031	4,555		13,586	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,304	4,647	1,459	15,410	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.46%

#REF!

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

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 1,459

Medicare Intermediary Wisconsin Physician Services

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

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

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

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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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	117,498	987	5,824	124,309		124,309		124,309		1
2	Food Purchase		100,589		100,589		100,589	(296)	100,293		2
3	Housekeeping	38,481	1,502		39,983		39,983		39,983		3
4	Laundry	41,923	23,047		64,970		64,970		64,970		4
5	Heat and Other Utilities			65,566	65,566		65,566		65,566		5
6	Maintenance	20,357	4,896	30,017	55,270		55,270		55,270		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	218,259	131,021	101,407	450,687		450,687	(296)	450,391		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			2,400	2,400		2,400		2,400		9
10	Nursing and Medical Records	716,414	59,576	1,647	777,637		777,637		777,637		10
10a	Therapy			141,596	141,596		141,596		141,596		10a
11	Activities	18,194	4,490	4,675	27,359		27,359		27,359		11
12	Social Services	31,855			31,855		31,855		31,855		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	766,463	64,066	150,318	980,847		980,847		980,847		16
	<b>C. General Administration</b>										
17	Administrative	98,572		955	99,527		99,527		99,527		17
18	Directors Fees										18
19	Professional Services			48,338	48,338		48,338	(6,183)	42,155		19
20	Dues, Fees, Subscriptions & Promotions			6,454	6,454		6,454		6,454		20
21	Clerical & General Office Expenses	41,679	8,033	9,233	58,945		58,945		58,945		21
22	Employee Benefits & Payroll Taxes			144,165	144,165		144,165	296	144,461		22
23	Inservice Training & Education										23
24	Travel and Seminar			855	855		855		855		24
25	Other Admin. Staff Transportation			7,622	7,622		7,622		7,622		25
26	Insurance-Prop.Liab.Malpractice			43,113	43,113		43,113		43,113		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	140,251	8,033	260,735	409,019		409,019	(5,887)	403,132		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,124,973	203,120	512,460	1,840,553		1,840,553	(6,183)	1,834,370		29

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

#REF!

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7**	8		
30	Depreciation			38,295	38,295		38,295	9,702	47,997		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			274	274		274	(274)			32
33	Real Estate Taxes			26,550	26,550		26,550		26,550		33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			491	491		491		491		35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			65,610	65,610		65,610	9,428	75,038		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		66,076	35	66,111		66,111		66,111		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			39,358	39,358		39,358		39,358		42
43	Other (specify):* <b>Non-allowable cost</b>			26,964	26,964		26,964	(26,964)			43
44	<b>TOTAL Special Cost Centers</b>		66,076	66,357	132,433		132,433	(26,964)	105,469		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,124,973	269,196	644,427	2,038,596		2,038,596	(23,719)	2,014,877		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.

#REF!

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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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	9,702	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	(655)	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	(1,869)	43		19
20	Contributions	(371)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(5,751)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(10,202)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A	(14,573)	Var.		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (23,719)		\$	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	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (23,719)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY							
48		49		50		51	

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs Part A	\$ (2,674)	43	1
2	X Rays Part A	(6,011)	43	2
3	Medicare Services	(1,866)	43	3
4	Offset Interst Inc against Interest Exp	(274)	32	4
5	Medical Supplies Part A	(3,023)	43	5
6	Transportation Medicare	(675)	43	6
7	Non Deductible Expenses	(50)	43	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
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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	<b>Total</b>	(14,573)		49

#REF!

**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			N/A				2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

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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	13	40.00	Salary	\$ 16,800	17(1)	1
2			Office Manager			19	60.00	Salary	25,200	21(1)	2
3											3
4	George W. White	Vice President	Co-Administrator	50.00	0	0	45.00	Salary	15,855	17(1)	4
5			Maintenance			0	55.00	Salary	17,324	6(1)	5
6											6
7	Bryan White	None	Asst. Admin	0.00	0	32	80.00	Salary	33,104	17(1)	7
8			Clerical			8	20.00	Salary	8,276	21(1)	8
9											9
10	Rachel White	None	Asst. Admin	0.00	0	32	80.00	Salary	32,813	17(1)	10
11			Clerical			8	20.00	Salary	8,203	21(1)	11
12											12
13								TOTAL	\$ 157,575		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

#REF!

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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

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

Name of Related Organization \_\_\_\_\_

Street Address N/A

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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									5
6									6
7			N/A						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			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1							\$	\$			\$	1						
2												2						
3												3						
4												4						
5												5						
<b>Working Capital</b>																		
6	State Bank of Ashland		X			1/31/09	25,000		3/3/09	Variable	99	6						
7	State Bank of Ashland		X			4/30/09	7,500		6/1/09	Variable	65	7						
8												8						
9	<b>TOTAL Facility Related</b>						\$ 32,500	\$			\$ 164	9						
<b>B. Non-Facility Related*</b>																		
10										Misc Int Exp-IL Dept of Emp Security	110	10						
11										Disallow nonallowable interest expense	(274)	11						
12												12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (164)	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 32,500	\$			\$	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.) #REF!

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

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

**B. Real Estate Taxes**

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax

1. Real Estate Tax accrual used on 2008 report.		\$	<b>20,471</b>	<b>1</b>
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	<b>2008</b>	\$	<b>25,316</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>4,845</b>	<b>3</b>
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>21,705</b>	<b>4</b>
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		<b>5</b>
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>26,550</b>	<b>7</b>
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	<b>2004</b>	<b>23,509</b>	<b>8</b>	
	<b>2005</b>	<b>27,408</b>	<b>9</b>	
	<b>2006</b>	<b>25,764</b>	<b>10</b>	
	<b>2007</b>	<b>24,768</b>	<b>11</b>	
	<b>2008</b>	<b>25,316</b>	<b>12</b>	
<b>Accrual based on 9/12 of current real estate tax bill.</b>				

<b>FOR BHF USE ONLY</b>			
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2008	\$	<b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

#REF!



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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

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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	Resident Care	22,176	1955	\$ 11,000	1
2	Resident Care	9,504	1981	23,604	2
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			363,607	5
6	5	1981	1981	79,226		30	2,641	2,641	75,878	6
7	16	1985	1985	399,782		30	13,326	13,326	319,820	7
8										8
	<b>Improvement Type**</b>									
9	Leasehold Improvement		1974	900		Various			900	9
10	Leasehold Improvement		1975	200		Various			200	10
11	Leasehold Improvement		1977	2,889		Various			2,889	11
12	Leasehold Improvement		1982	552		Various			552	12
13	Leasehold Improvement		1983	533		Various			533	13
14	Leasehold Improvement		1984	11,510		Various			11,510	14
15	Leasehold Improvement		1985	70,113		Various			70,133	15
16	Leasehold Improvement		1986	7,764	16	Various	204	188	6,441	16
17	Leasehold Improvement		1988	2,015	64	Various	66	2	1,403	17
18	Leasehold Improvement		1990	2,480		Various			2,480	18
19	Leasehold Improvement		1991	23,204	684	Various	781	97	14,139	19
20	Leasehold Improvement		1992	45,806	1,455	Various	1,504	49	26,782	20
21	Leasehold Improvement		1993	11,951	364	Various	374	10	6,048	21
22	Leasehold Improvement		1995	4,939	62	Various	62		4,604	22
23	Leasehold Improvement		1996	6,289		Various			6,289	23
24	Leasehold Improvement		1997	63,654	2,132	Various	2,132		26,173	24
25	Leasehold Improvement		1998	45,605	1,169	Various	1,144	(25)	12,655	25
26	Leasehold Improvement		1999	2,066	53	Various	53		554	26
27	Leasehold Improvement		2000	4,528	113	10	453	340	3,849	27
28										28
29	Shower faucets		2000	1,550	39	10	155	116	1,318	29
30	Door locks		2001	1,500	150	10	150		1,125	30
31	Water heater		2002	4,283	107	10	428	321	2,926	31
32	New roof		2004	28,437	711	39	711		3,910	32
33	Flooring		2005	5,323	133	39	136	3	572	33
34	Tiling in Showers		2005	1,062	27	39	27		109	34
35	Sprinkler		2006	860	13	39	12	(1)	48	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

#REF!

Facility Name & ID Number Walker Nursing Home

# 0021428

Report Period Beginning:

10/1/08

Ending:

9/30/09

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	\$ 2,779	37
38	Water line	2007	7,175	15	40	179	164	448	38
39	Concrete work for entrance and walkways	2007	64,272	536	20	1,606	1,070	4,819	39
40	Parking lot blacktop & striping	2007	33,585	280	20	1,680	1,400	4,200	40
41	Manor landscaping improvements	2007	10,560	44	20	525	481	1,314	41
42	Roof repairs	2006	3,250		20	163	163	427	42
43									43
44	Toilets & installation	2008	15,426	386	20	771	385	1,157	44
45	New railings	2008	6,315	158	20	316	158	474	45
46	Iron fence	2008	4,895	122	20	245	123	367	46
47	Major landscaping	2008	11,721	293	20	586	293	879	47
48									48
49	Sewer cable machine	2009	2,899	2,899	10	145	(2,754)	145	49
50	Water heater	2009	5,998	122	40	75	(47)	75	50
51	Air conditioner-10 Ton	2009	9,995	118	40	125	7	125	51
52	6 Heating / cooling units	2009	3,356	3,356	10	168	(3,188)	168	52
53	Water heater	2009	5,140	50	40	64	14	64	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)		\$ 1,549,994	\$ 16,200		\$ 32,064	\$ 15,864	\$ 1,115,411	70

#REF!

\*\*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	\$ 21,010	\$ 14,848	\$ (6,162)	3-39 Yrs	\$ 686,246	71
72	Current Year Purchases	4,182	1,085	1,085		3-39 Yrs	1,085	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 747,802	\$ 22,095	\$ 15,933	\$ (6,162)		\$ 687,331	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)	\$ 2,377,383	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 38,295	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 47,997	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 9,702	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,847,725	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.

#REF!

**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?  YES  NO

If NO, see instructions.

		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: \$ 491 Description: Oxygen - \$491

(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.	<u>/2010</u>	\$ _____
13.	<u>/2011</u>	\$ _____
14.	<u>/2012</u>	\$ _____

\* 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? <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			
		1	2	3	4
		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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**

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

###

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

	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	\$	920	\$ 55,171	\$	920	\$ 55,171	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		94	5,658		94	5,658	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		1,346	80,767		1,346	80,767	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				66,076		66,076	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Other Medical Services	L39, C8				35			35	13
14	TOTAL			\$	2,360	\$ 141,631	\$ 66,076	2,360	\$ 207,707	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.

#REF!

Facility Name & ID Number Walker Nursing Home

# 0021428

Report Period Beginning: 10/1/08

Ending:

9/30/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/09

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 37,197	\$ 37,197	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>Zero</u> )	352,547	352,547	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments	248,202	248,202	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	93,315	93,315	8
9	Other(specify): <u>See Schedule 17A</u>	4,808	4,808	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 736,069	\$ 736,069	10
	<b>B. Long-Term Assets</b>			
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	1,002,779	973,138	14
15	Leasehold Improvements, at Historical Cost	501,535	576,856	15
16	Equipment, at Historical Cost	821,898	792,785	16
17	Accumulated Depreciation (book methods)	(1,896,406)	(1,847,725)	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): <u>\$444 Election Deposit</u>	4,809	4,809	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 471,243	\$ 536,491	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,207,312	\$ 1,272,560	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 67,445	\$ 67,445	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	32,772	32,772	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	21,705	21,705	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Other Current Liabilities</u>	12,607	12,607	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 134,529	\$ 134,529	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 134,529	\$ 134,529	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,072,783	\$ 1,138,031	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,207,312	\$ 1,272,560	48

#REF!

\*(See instructions.)

Walker Nursing Home

Facility ID#: 0021428

Year 9/30/2009

Schedule 17A

Line 9 - Other Current Assets

Income Tax Refund Receivable	1,056
Federal Tax Refund	422
Employee Advances	690
Advances - Other	2,640
	<u>4,808</u>

Line 36 - Other Current Liabilities

State Withholding	(10)
Christmas Club Withholding	9,800
Employee Garnishment	405
State Unemployment Payable	1,815
Federal Unemployment Payable	597
	<u>12,607</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,005,760</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>	<b>Prior Period Adjustment</b>	<b>(55,306)</b>	<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>950,454</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>94,677</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>27,652</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>122,329</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,072,783</b>	<b>24</b> *

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

#REF!

**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	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 2,154,924	1
2	Discounts and Allowances for all Levels	(15,427)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,139,497	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	4,013	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 4,013	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28		(10,237)	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ (10,237)	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,133,273	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	450,687	31
32	Health Care	980,847	32
33	General Administration	409,019	33
	<b>B. Capital Expense</b>		
34	Ownership	65,610	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	93,075	35
36	Provider Participation Fee	39,358	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,038,596	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	94,677	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 94,677	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. #REF!

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

Facility Name & ID Number Walker Nursing Home

# 0021428

Report Period Beginning:

10/1/08

Ending:

9/30/09

**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	2,085	2,146	\$ 41,690	\$ 19.43	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,671	2,707	67,464	24.92	3
4	Licensed Practical Nurses	15,976	16,414	326,929	19.92	4
5	CNAs & Orderlies	28,150	28,908	280,331	9.70	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,853	1,884	18,194	9.66	9
10	Activity Assistants					10
11	Social Service Workers	2,051	2,106	31,855	15.13	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,316	2,404	29,154	12.13	14
15	Cook Helpers/Assistants	9,800	10,090	88,344	8.76	15
16	Dishwashers					16
17	Maintenance Workers	1,444	1,472	20,357	13.83	17
18	Housekeepers	4,764	4,896	38,481	7.86	18
19	Laundry	4,636	4,753	41,923	8.82	19
20	Administrator	1,739	1,782	32,655	18.32	20
21	Assistant Administrator	3,337	3,419	65,917	19.28	21
22	Other Administrative					22
23	Office Manager	1,227	1,258	25,776	20.49	23
24	Clerical	834	855	15,903	18.60	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)	82,883	85,094	\$ 1,124,973 *	\$ 13.22	34

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	416	\$ 5,824	L1, C3	35
36	Medical Director	Monthly	2,400	L9, C8	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	4,675	L11, C3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	416	\$ 12,899		49

**C. CONTRACT NURSES**

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

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

\*\* See instructions.

###

Facility Name & ID Number Walker Nursing Home

# 0021428

Report Period Beginning: 10/1/08

Ending: 9/30/09

**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	\$ 15,855	Workers' Compensation Insurance	\$ 22,325	IDPH License Fee	\$ 1,990	
Mary Ann White	Co-Administrator	50	16,800	Unemployment Compensation Insurance	10,807	Advertising: Employee Recruitment	3,099	
Bryan White	Asst. Administrator	0	33,104	FICA Taxes	85,345	Health Care Worker Background Check		
Rachel White	Asst. Administrator	0	32,813	Employee Health Insurance	22,456	(Indicate # of checks performed 17 )	250	
				Employee Meals	296	Patient Background Checks	17 250	
				Illinois Municipal Retirement Fund (IMRF)*		Illinois Nursing Home Admin. Assn.	385	
				Other Employee Benefits	3,232	Other Subscriptions & Licenses	480	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 98,572					
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
RSM McGladrey	Accounting		\$ 38,644	N/A			Out-of-State Travel	\$
Londrigan, Potter & Randle	Legal Services		2,714					
Cavanaugh & O'Hara	Legal Services		3,037					
Global Times Systems	Time Clock Services		79				In-State Travel	
Pathway Health Services	Operations & Billing		500					
Accu-Med Services	Operations & Billing		1,130					
Contemporary Concepts	Funeral Pamphlet Publisher		432				Seminar Expense	855
Computer Concepts	Computer Services		1,095					
On Hold Productions	Phone Answering		574					
Ivans	Medicare Billing		46					
Total from Sch 21A			87				Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V,	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 48,338				line 24, col. 8)	\$ 855

\* Attach copy of IMRF notifications

\*\*See instructions.

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Walker Nursing Home  
FYE 9/30/09  
Schedule 21A

Schedule21A

**Pg 21C - Professional Services**

Professional Services per Page 19 Section C	48,251
Add: Pastor Jill Tracy Ministerial	75
Add: Enloe Pharmacy Software Svcs	12
Per Schedule agreeing with P3, L19, C3	48,338
Less: Reclass to Promotional Account	(432)
Less : Disallowed Legal Expense	<u>(5,751)</u>
Total agreeing with P3, L19, C8	<u><u>42,155</u></u>

**SEE ACCOUNTANTS' COMPILATION 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								
					FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3								N/A					
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

#REF!

Facility Name &amp; ID Number Walker Nursing Home

# 0021428

Report Period Beginning:

10/1/08

Ending:

9/30/09

## XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IL Nursing Home Admin Assn. - \$385
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 3-39 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 11 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. \$ 39,358  
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.

#REF!

- (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. \$ 296 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 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
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? No  
Attach invoices and a summary of services for all architect and appraisal fees.