

		FOR OHF USE				

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**2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)**

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

<p>I. IDPH Facility ID Number: <u>0040972</u></p> <p>Facility Name: <u>Parkway Manor</u></p> <p>Address: <u>3116 Williamson County Parkway</u> <u>Marion</u> <u>62959</u> Number City Zip Code</p> <p>County: <u>Williamson</u></p> <p>Telephone Number: <u>(618) 993-8600</u> Fax # <u>(618) 993-5887</u></p> <p>IDPA ID Number: <u>37-1223745009</u></p> <p>Date of Initial License for Current Owners: <u>05/11/95</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Ron Wilson</u> Telephone Number: <u>(309) 343-1550</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/01</u> to <u>12/31/01</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 20%;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Date)</td> </tr> <tr> <td>(Type or Print Name) <u>Ron Wilson</u></td> </tr> <tr> <td></td> <td>(Title) <u>Chief Financial Officer</u></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) <u>See Independent Accountant's Report</u> (Date)</td> </tr> <tr> <td>(Print Name and Title) <u>McGladrey & Pullen, LLP</u></td> </tr> <tr> <td>(Firm Name & Address) <u>117 East Main, Suite 210, P.O. Box 1070 Galesburg, Illinois 61402</u></td> </tr> <tr> <td>(Telephone) <u>(309) 342-1175</u> Fax # <u>(309) 342-7816</u></td> </tr> </table> <p align="center">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date)	(Type or Print Name) <u>Ron Wilson</u>		(Title) <u>Chief Financial Officer</u>	Paid Preparer	(Signed) <u>See Independent Accountant's Report</u> (Date)	(Print Name and Title) <u>McGladrey & Pullen, LLP</u>	(Firm Name & Address) <u>117 East Main, Suite 210, P.O. Box 1070 Galesburg, Illinois 61402</u>	(Telephone) <u>(309) 342-1175</u> Fax # <u>(309) 342-7816</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																	
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Parkway Manor

0040972 Report Period Beginning: 1/1/01 Ending: 12/31/01

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>119</u>	Skilled (SNF)	<u>119</u>	<u>43,435</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>119</u>	TOTALS	<u>119</u>	<u>43,435</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	4 Other		
8	SNF	<u>3,157</u>	<u>5,349</u>	<u>5,262</u>	<u>13,768</u>	8
9	SNF/PED					9
10	ICF	<u>6,313</u>	<u>17,100</u>	<u>0</u>	<u>23,413</u>	10
11	ICF/DD					11
12	SC			<u>0</u>		12
13	DD 16 OR LESS					13
14	TOTALS	<u>9,470</u>	<u>22,449</u>	<u>5,262</u>	<u>37,181</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.60%

D. How many bed-hold days during this year were paid by Public Aid? 2 (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 05/11/95

J. Was the facility purchased or leased after January 1, 1978?
YES Date 04/18/95 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 26 and days of care provided 5,262

Medicare Intermediary AdminaStar Federal Inc.

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/01 Fiscal Year: 12/31/01
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number

Parkway Manor

0040972

Report Period Beginning:

1/1/01

Ending:

12/31/01

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	161,751	17,937	15,200	194,888		194,888		194,888		1
2	Food Purchase		172,492		172,492		172,492	(2,324)	170,168		2
3	Housekeeping	108,736	23,058		131,794		131,794		131,794		3
4	Laundry	35,549	24,056		59,605		59,605		59,605		4
5	Heat and Other Utilities			102,972	102,972		102,972	323	103,295		5
6	Maintenance	49,829	44,798	41,256	135,883		135,883	463	136,346		6
7	Other (specify):*										7
8	TOTAL General Services	355,865	282,341	159,428	797,634		797,634	(1,538)	796,096		8
	B. Health Care and Programs										
9	Medical Director			5,500	5,500		5,500		5,500		9
10	Nursing and Medical Records	1,320,633	175,048	2,318	1,497,999		1,497,999		1,497,999		10
10a	Therapy	222,249		17,904	240,153		240,153		240,153		10a
11	Activities	52,594	4,115	282	56,991		56,991		56,991		11
12	Social Services	35,589			35,589		35,589		35,589		12
13	Nurse Aide Training										13
14	Program Transportation			165	165	510	675		675		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,631,065	179,163	26,169	1,836,397	510	1,836,907		1,836,907		16
	C. General Administration										
17	Administrative	80,932			80,932		80,932	81,797	162,729		17
18	Directors Fees										18
19	Professional Services			167,753	167,753		167,753	(153,139)	14,614		19
20	Dues, Fees, Subscriptions & Promotions			24,593	24,593		24,593	(9,355)	15,238		20
21	Clerical & General Office Expenses	36,005	23,228	24,993	84,226		84,226	7,005	91,231		21
22	Employee Benefits & Payroll Taxes			329,907	329,907		329,907	13,025	342,932		22
23	Inservice Training & Education			1,254	1,254		1,254		1,254		23
24	Travel and Seminar			4,610	4,610		4,610	2,604	7,214		24
25	Other Admin. Staff Transportation			1,019	1,019	(510)	509	3,172	3,681		25
26	Insurance-Prop.Liab.Malpractice			59,649	59,649		59,649	233	59,882		26
27	Other (specify):* See Attached Sch VI			5,426	5,426		5,426	(5,426)			27
28	TOTAL General Administration	116,937	23,228	619,204	759,369	(510)	758,859	(60,084)	698,775		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,103,867	484,732	804,801	3,393,400		3,393,400	(61,622)	3,331,778		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

Parkway Manor

#0040972

Report Period Beginning:

1/1/01

Ending:

12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			17,768	17,768		17,768	162,040	179,808			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			851	851		851	167,638	168,489			32
33	Real Estate Taxes			121,440	121,440		121,440	285	121,725			33
34	Rent-Facility & Grounds			492,660	492,660		492,660	(488,784)	3,876			34
35	Rent-Equipment & Vehicles			15,734	15,734		15,734	650	16,384			35
36	Other (specify):* Amortization							4,247	4,247			36
37	TOTAL Ownership			648,453	648,453		648,453	(153,924)	494,529			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			16,602	16,602		16,602		16,602			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,153	65,153		65,153		65,153			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			81,755	81,755		81,755		81,755			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,103,867	484,732	1,535,009	4,123,608		4,123,608	(215,546)	3,908,062			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Parkway Manor

0040972

Report Period Beginning: 1/1/01

Ending: 12/31/01

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(500)	2		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	4,507	30		9
10	Interest and Other Investment Income	(41,595)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,824)	2		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				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(4,950)	27		24
25	Fund Raising, Advertising and Promotional	(5,373)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(3,996)	20		28
29	Other-Attach Schedule See Attached Schedule VII	(1,752)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (55,483)		\$	30

OHF USE ONLY					
48		49	50	51	52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense		31	33
34	Adjustments for Related Organization Costs (Schedule VII)	(160,063)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (160,063)		36
37	TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)	\$ (215,546)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Parkway Manor

ID# 0040972

Report Period Beginning: 1/1/01

Ending: 12/31/01

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
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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	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Parkway Manor

0040972

Report Period Beginning:

1/1/01

Ending:

12/31/01

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	(2,324)	0	0	0	0	0	0	0	0	0	0	(2,324)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,324)	0	0	0	0	0	0	0	0	0	0	(2,324)	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	Nurse Aide 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	(35,243)	0	0	0	0	0	0	0	0	0	(35,243)	19
20	Fees, Subscriptions & Promotions	(9,369)	0	0	0	0	0	0	0	0	0	0	(9,369)	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):*	(4,950)	0	0	0	0	0	0	0	0	0	0	(4,950)	27
28	TOTAL General Administration	(14,319)	(35,243)	0	(49,562)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(16,643)	(35,243)	0	(51,886)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Parkway Manor

0040972 Report Period Beginning:

1/1/01 Ending:

12/31/01

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

	Capital Expense	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)
	D. Ownership												
30	Depreciation	4,507	0	0	0	0	0	0	0	0	0	0	4,507 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(41,595)	0	0	0	0	0	0	0	0	0	0	(41,595) 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	(124,820)	0	0	0	0	0	0	0	0	0	(124,820) 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	(37,088)	(124,820)	0	(161,908) 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):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0 44
	GRAND TOTAL COST												
45	(sum of lines 29, 37 & 44)	(53,731)	(160,063)	0	(213,794) 45								

Facility Name & ID Number Parkway Manor

0040972

Report Period Beginning:

1/1/01

Ending:

12/31/01

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
Illini Manors, Inc. (100% owned by Don Fike)	100%	See Attached Schedule I		RFMS, Inc.	Galesburg	Admin. Svcs.
				L B Properties, Inc.	Galesburg	Lessor

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	34 Facility Rental	492,660	L B Properties, Inc. (77.6% owned by Don Fike)	None	367,840	(124,820)	2
3	V							3
4	V							4
5	V	19 Administrative Services	156,000	RFMS, Inc. (100% owned by Don Fike)	None	120,757	(35,243)	5
6	V							6
7	V							7
8	V							8
9	V			See Attached Schedules III and IV				9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 648,660			\$ 488,597	\$ * (160,063)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Parkway Manor # 0040972 Report Period Beginning: 1/1/01 Ending: 12/31/01

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								\$		1	
2	Don Fike	President	Management	100.00	See Attached Schedule III	>40	100.00	Salary	8,614	17-7	2
3								Benefits	580	22-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 9,194		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 Parkway Manor # 0040972 Report Period Beginning: 1/1/01 Ending: 12/31/01

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 _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2	3	4	5	6		8	9	10									
						Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES							NO	Original				Balance
	A. Directly Facility Related																		
	Long-Term																		
1						\$	\$			\$	1								
2	Bank One, Springfield	x	Refinanced building mortgage	Varies Pd	05/09/96	3,952,706	2,990,712	04/01/11	6.6600	209,083	2								
3				Quarterly							3								
4	Interest Income Adjustment		From page 5, line 10							(41,595)	4								
5											5								
	Working Capital																		
6											6								
7	Miscellaneous Vendors	x	Miscellaneous operating							851	7								
8	Home Office Allocation Adj.		See Attached Schedule III							150	8								
9	TOTAL Facility Related					\$ 3,952,706	\$ 2,990,712			\$ 168,489	9								
	B. Non-Facility Related*																		
10											10								
11											11								
12											12								
13											13								
14	TOTAL Non-Facility Related					\$	\$			\$	14								
15	TOTALS (line 9+line14)					\$ 3,952,706	\$ 2,990,712			\$ 168,489	15								

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 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 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 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 Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Parkway Manor COUNTY Williamson

FACILITY IDPH LICENSE NUMBER 0040972

CONTACT PERSON REGARDING THIS REPORT Ron Wilson

TELEPHONE (309) 343-1550 FAX #: (309) 343-2857

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 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 2000.

(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>06-10-301-023</u>	<u>L B Properties, Inc. 001-000-209</u>	\$ <u>146,457.00</u>	\$ <u>114,237.00</u>
2. <u>06-10-301-026</u>	<u>L B Properties, Inc. 002-000-209</u>	\$ <u>428.00</u>	\$ <u>428.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>146,885.00</u>	\$ <u>114,665.00</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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Parkway Manor

0040972 Report Period Beginning:

1/1/01 Ending:

12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 39,356 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1C. 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, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Parkway Estates Retirement Apartments 42 units 34,468 square feetF. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A3. Current Period Amortization: N/A 4. Dates Incurred: N/ANature of Costs: N/A

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	6.6 Acres	1993	\$ 244,382	1
2					2
3	TOTALS			\$ 244,382	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Parkway Manor

0040972

Report Period Beginning:

1/1/01

Ending:

12/31/01

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	119			1995	\$ 3,063,499	\$ 97,254	31	\$ 97,254	\$	\$ 656,465	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Total improvements by year constructed:										
10	1995			1995	138,120	6,906	20	6,906		46,616	10
11	1996			1996	65,950	4,053	15-20	4,295	242	23,051	11
12	1997			1997	27,510	1,906	15	1,834	(72)	8,686	12
13											13
14	Detailed improvements for the years 1998 - 2001:										
15	Mixing valve			2000	3,506	333	15	234	(99)	449	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

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Parkway Manor

0040972

Report Period Beginning:

1/1/01

Ending:

12/31/01

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			\$	\$		\$	\$	\$		37
38										38
39										39
40										40
41										41
42										42
43										43
44										44
45										45
46										46
47										47
48										48
49										49
50										50
51										51
52										52
53										53
54										54
55										55
56										56
57										57
58										58
59										59
60										60
61										61
62										62
63										63
64										64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 3,298,585	\$ 110,452		\$ 110,523	\$ 71	\$ 735,267		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	\$ 585,422	\$ 57,342	\$ 61,336	\$ 3,994	5-15 yrs	\$ 397,993	71
72	Current Year Purchases	15,114	2,031	1,377	(654)	5-10 yrs	1,377	72
73	Fully Depreciated Assets							73
74	Indirect Costs Allocated (See Attached Schedule III)		3,023	3,023				74
75	TOTALS	\$ 600,536	\$ 62,396	\$ 65,736	\$ 3,340		\$ 399,370	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	Patient Care	97 Ford Windstar Van	1997	\$ 21,296	\$ 2,453	\$ 3,549	\$ 1,096	4 yrs	\$ 21,296	76
77										77
78										78
79										79
80	TOTALS			\$ 21,296	\$ 2,453	\$ 3,549	\$ 1,096		\$ 21,296	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)	\$ 4,164,799	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 175,301	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 179,808	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 4,507	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,155,933	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: L B Properties, Inc.

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 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ <u>See Attached</u>			3
4	Additions				<u>Schedule IV -</u>			4
5					<u>Related Party</u>			5
6					<u>Lease</u>			6
7	TOTAL				\$ <u>***</u>			7

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. /2002 \$
13. /2003 \$
14. /2004 \$

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: \$ Description:

(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			\$ <u> </u>	\$ <u> </u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u> </u>	\$ <u> </u>	21

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

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

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

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

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>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 AIDE <u>All nurse aides have met training requirements.</u></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 AIDE _____</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	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (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 aide 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 aides.

C. CONTRACTUAL INCOME

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

\$ None

D. NUMBER OF AIDES TRAINED

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

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.
- 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		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	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 nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Parkway Manor

0040972

Report Period Beginning: 1/1/01

Ending:

12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/01

(last day of reporting year)

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

	1	2	
	Operating	After Consolidation*	
A. Current Assets			
1 Cash on Hand and in Banks	\$ 11,402	\$ 92,657	1
2 Cash-Patient Deposits	960	960	2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance)	552,139	977,934	3
4 Supply Inventory (priced at)			4
5 Short-Term Investments			5
6 Prepaid Insurance	78,485	105,976	6
7 Other Prepaid Expenses			7
8 Accounts Receivable (owners or related parties)		1,574,571	8
9 Other(specify): See Attached Schedule VIII	1,935,163	1,935,163	9
10 TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,578,149	\$ 4,687,261	10
B. Long-Term Assets			
11 Long-Term Notes Receivable			11
12 Long-Term Investments		104,078	12
13 Land		244,382	13
14 Buildings, at Historical Cost		3,063,499	14
15 Leasehold Improvements, at Historical Cost	96,966	369,896	15
16 Equipment, at Historical Cost	118,332	1,244,127	16
17 Accumulated Depreciation (book methods)	(133,623)	(1,778,343)	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): Loan Financing Costs			23
24 TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 81,675	\$ 3,247,639	24
25 TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,659,824	\$ 7,934,900	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$ 82,043	\$ 116,333	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits	960	960	28
29 Short-Term Notes Payable			29
30 Accrued Salaries Payable	178,163	304,115	30
31 Accrued Taxes Payable (excluding real estate taxes)	2,691	2,691	31
32 Accrued Real Estate Taxes(Sch.IX-B)	118,000	123,886	32
33 Accrued Interest Payable		16,598	33
34 Deferred Compensation			34
35 Federal and State Income Taxes			35
Other Current Liabilities(specify):			
36 Interdivision Payable			36
37 Other Accrued Liabilities			37
38 TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 381,857	\$ 564,583	38
D. Long-Term Liabilities			
39 Long-Term Notes Payable			39
40 Mortgage Payable		2,990,712	40
41 Bonds Payable			41
42 Deferred Compensation			42
Other Long-Term Liabilities(specify):			
43			43
44 Resident Security Deposits	102,328	102,328	44
45 TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 102,328	\$ 3,093,040	45
46 TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 484,185	\$ 3,657,623	46
47 TOTAL EQUITY(page 18, line 24)	\$ 2,175,639	\$ 4,277,277	47
48 TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,659,824	\$ 7,934,900	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,602,202	1
2	Restatements (describe):		2
3	Year-end adjustments made subsequent to the filing of the		3
4	prior year's Medicaid cost report. (See Attached Schedule IX)	11,403	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,613,605	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	562,034	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 562,034	17
B. Transfers (Itemize):			
18	Interdivision transfers		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)	\$ 2,175,639	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Parkway Manor

0040972

Report Period Beginning: 1/1/01

Ending: 12/31/01

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	\$ 4,636,240	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,636,240	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	40,489	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 40,489	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	631	12
13	Barber and Beauty Care	3,651	13
14	Non-Patient Meals	500	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 4,782	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	201	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 201	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Activity Fund Income		28
28a	Durable Medical Equipment	3,930	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,930	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,685,642	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	797,634	31
32	Health Care	1,836,397	32
33	General Administration	759,369	33
B. Capital Expense			
34	Ownership	648,453	34
C. Ancillary Expense			
35	Special Cost Centers	16,602	35
36	Provider Participation Fee	65,153	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,123,608	40
41	Income before Income Taxes (line 30 minus line 40)**	562,034	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 562,034	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. See Attached Schedule V

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

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

Facility Name & ID Number Parkway Manor

0040972

Report Period Beginning: 1/1/01

Ending:

12/31/01

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	102	102	\$ 1,965	\$ 19.26	1
2	Assistant Director of Nursing	1,919	2,042	29,607	14.50	2
3	Registered Nurses	6,062	6,449	92,608	14.36	3
4	Licensed Practical Nurses	23,506	25,006	294,826	11.79	4
5	Nurse Aides & Orderlies	94,089	100,094	772,727	7.72	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	1,392	1,481	53,534	36.15	7
8	Rehab/Therapy Aides	9,199	9,786	168,715	17.24	8
9	Activity Director	2,785	2,963	26,340	8.89	9
10	Activity Assistants	4,277	4,550	26,254	5.77	10
11	Social Service Workers	3,713	3,950	35,589	9.01	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,877	23,274	161,751	6.95	15
16	Dishwashers					16
17	Maintenance Workers	6,245	6,644	49,829	7.50	17
18	Housekeepers	15,031	15,991	108,736	6.80	18
19	Laundry	5,514	5,866	35,549	6.06	19
20	Administrator	1,955	2,080	54,658	26.28	20
21	Assistant Administrator	1,955	2,080	26,274	12.63	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,282	3,491	36,005	10.31	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	1,760	1,872	15,727	8.40	31
32	Other Health Care Supervisors	11,366	12,091	113,173	9.36	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	216,029	229,812	\$ 2,103,867 *	\$ 9.15	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	***	\$ 15,200	1-3	35
36	Medical Director	***	5,500	9-3	36
37	Medical Records Consultant	***	1,418	10-3	37
38	Nurse Consultant	***		10-3	38
39	Pharmacist Consultant	***	900	10-3	39
40	Physical Therapy Consultant	***	17,904	10a-3	40
41	Occupational Therapy Consultant	***	0	10a-3	41
42	Respiratory Therapy Consultant	***		10a-3	42
43	Speech Therapy Consultant	***	0	10a-3	43
44	Activity Consultant	***		11-3	44
45	Social Service Consultant	***	0	12-3	45
46	Other(specify) Dental Consultant	***	0	10-3	46
47	Psychological Consultant	***		10-3	47
48	***=Monthly Fee Arrangement				48
49	TOTAL (lines 35 - 48)		\$ 40,922		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	Nurse Aides			52
53	TOTAL (lines 50 - 52)	\$		53

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										
1	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year									
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	
2	None		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	
3														
4														
5														
6														
7														
8														
9														
10														
11														
12														
13														
14														
15														
16														
17														
18														
19														
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Parkway Manor

0040972

Report Period Beginning:

1/1/01

Ending:

12/31/01

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. See page 21, Section F
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (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? 8 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 4,749 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 65,153
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? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, 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. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 500
- (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? None
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- 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? Yes
Firm Name: McGladrey & Pullen, LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit not yet completed.
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT

FACILITY NAME: Parkway Manor

YEAR ENDED: 12/31/01

COST REPORT GROUPINGS
DATA INPUT SHEET

Cost Center	Cost Type	Grouping Code	\$ Amount	Balance Sheet	Grouping Code	\$ Amount
Dietary	Labor	1-1	161,751	Cash	A1	11,402
Dietary	Supplies	1-2	17,937	Patient Deposits	A2	960
Dietary	Other	1-3	15,200	Accounts Receivable	A3	552,139
Nursing	Labor	10-1	1,320,633	Prepaid Insurance	A6	78,485
Nursing	Supplies	10-2	175,048	Other Prepaid Exp	A7	0
Nursing	Other	10-3	2,318	Related Party Rec'ble	A8	0
Therapy	Labor	10A-1	222,249	Interdivision Receivable	A9	1,935,163
Therapy	Other	10A-3	17,904	Interest Receivable	A9a	0
Activities	Labor	11-1	52,594	Long-Term Investments	B12	0
Activities	Supplies	11-2	4,115	Land	B13	0
Activities	Other	11-3	282	Buildings	B14	0
SocSerDir	Labor	12-1	35,589	Leasehold Improve	B15	96,966
SocSerDir	Other	12-3	0	Equipment	B16	118,332
NurseAideTrng	Labor	13-1	0	Accum Depreciation	B17	(133,623)
NurseAideTrng	Supplies	13-2	0	Deferred Maintenance	B18	0
NurseAideTrng	Other	13-3	0	Org & Pre-Op Costs	B19	0
ProgramTransp	Other	14-3	165	Accum Amortization	B20	0
Administrative	Labor	17-1	80,932	Loan Financing Costs	B23a	0
Prof. Services	Other	19-3	167,753	Leasehold Deposit	B23b	0
FoodPurchase	Supplies	2-2	172,492			
Fees,Subs&Promo	Other	20-3	24,593	Total Assets		<u>2,659,824</u>
Clerical&GO	Labor	21-1	36,005	Accounts Payable	C26	82,043
Clerical&GO	Supplies	21-2	23,228	A/P-Patient Deposits	C28	960
Clerical&GO	Other	21-3	24,993	Accrued Salaries	C30	178,163
EmployeeBen	Other	22-3	329,907	Accrued Taxes	C31	2,691
Inservice Training	Other	23-3	1,254	AccrRealEstateTax	C32	118,000
Travel	Other	24-3	2,133	Accrued Interest	C33	0
Seminar	Other	24-3a	2,477	Interdivision Payable	C36	0
Admin Staff Transp	Other	25-3	1,019	Other Current Liab	C37	0
Insurance	Other	26-3	59,649	Mortgage Payable	D40	0
Bad Debts	Other	27-3	4,950	Security Deposits	D44	102,328
Lobbying	Other	27-3a	476	Retained Earnings	E1	1,613,605
Housekeeping	Labor	3-1	108,736	Distributions	E13	0
Housekeeping	Supplies	3-2	23,058	Transfers	E18	0
Housekeeping	Other	3-3	0	Total Liab & Equity		<u>2,097,790</u>
Depreciation	Other	30-3	17,768			
Amort of Pre-Op	Other	31-3	0	Net Income(Loss)		562,034
Interest	Other	32-3	851	Ending RE		2,175,639
RealEstateTax	Other	33-3	121,440			
Rent-Facility	Other	34-3	492,660	Gross Revenue	R1	4,636,240
Rent-Equip&Vehicl	Other	35-3	15,734	NurseAideTrngReimb	R11	0
Amortization	Other	36-3	0	Vending	R12	631
Ancillary	Labor	39-1	0	Barber & Beauty	R13	3,651
Ancillary	Other	39-3	16,602	Non-Patient Meals	R14	500
Laundry	Labor	4-1	35,549	Telephone & TV	R15	0
Laundry	Supplies	4-2	24,056	Non-Patient Supplies	R18	0
Vending	Other	41-3	0	Contributions	R24	0
ProvParticFee	Other	42-3	65,153	Interest	R25	201
Utilities	Other	5-3	102,972	Recoveries	R28	0
Maintenance	Labor	6-1	49,829	Durable Med Equip	R28a	3,930
Maintenance	Supplies	6-2	44,798	Gain(loss)-equipment	R28b	0
Maintenance	Other	6-3	41,256	Outpatient Services	R5	0
MedicalDirector	Other	9-3	5,500	Therapy	R6	40,489
				Oxygen	R7	0
				Income Tax (expense)	R42	0
				Total Revenue		<u>4,685,642</u>
				Total Costs		<u>4,123,608</u>
				Net Income(Loss)		562,034
				Input Error (s/lb -0-)		0

FACILITY NAME: Parkway Manor YEAR ENDED: 12/31/01

**OTHER INFORMATION
DATA INPUT SHEET**

Sales Tax	<u>1,824</u>	Beginning Equity Adjustments	
(Grouping Code 2-2 a/c # 9850 - Sales Tax)		Uncollectible patient accounts	0
Diaper Expense	<u>4,749</u>	Medicare cost report settlements	11,403
(Grouping Code 10-2 a/c # 4115 - Incontinence)		Related party accrued interest income	0
Prior Year Ending Equity	<u>0</u>	Workers' comp insurance	0
(page 17, line 47)	var	Miscellaneous	0
Prior Year Accrued Real Estate Tax	<u>111,235</u>	Illinois replacement tax	0
(page 17, line 32)			
Amount of Note - Original	<u>3,952,706</u>	Net Prior Period Adjustments	<u>11,403</u>
(prior year page 9, column 6)			
Accrued Employee Time	<u>Ending 64,600</u>	Tax Return Info	
(Grouping Code C30, a/c # 1715)	<u>Beginning 65,755</u>	Meals expenses:	14-3 0
		(by grouping code)	23-3 31
			24-3 0
Vehicle Expense	<u>614</u>		24-3a 0
(Grouping Code 25-3 a/c # 9305)		50% tax limitation =	16 31
Interdivision Transfers	<u>0</u>	Tax depreciation expense	<u>16,221</u>
var	0		
Shareholder Distributions	<u>0</u>	Capital Lease Depreciation	<u>154,510</u>
var	0		
MEDICARE BEDS	<u>Ending 26</u>	Fines and Penalties	<u>0</u>
CENSUS INFORMATION (beds)	<u>Beginning 119</u>	Out-of-State Training	<u>1,276</u>
	<u>Ending 119</u>		

SALARY COSTS		Page 20 Line/Amt	
1,320,633	10-1 4000	1,965	1,965
0	4005	29,607	29,607
var	4006	21,660	113,173
	4007	0	32
	4008	15,727	31 15,727
	4010	54,334	3 92,608
	4011	38,274	3
	4015	294,826	4 294,826
	4016	0	4
	4018	66,985	32
	4020	482,317	5 772,727
	4021	24,528	32
	4022	173,964	5
	4023	54,504	5
	4024	31,567	5
	4025	30,375	5
	4026	0	5
222,249	10A-1 4050	12,180	7 53,534
0	4051	102,977	8 168,715
	4052	0	8
	4055	8,188	7
	4056	65,738	8
	4060	33,166	7
52,594	11-1 2000	26,340	9 26,340
0	2005	26,254	10 26,254
80,932	17-1 8000	54,658	20 54,658
0	8005	26,274	21 26,274
	Total	<u>1,676,408</u>	<u>1,676,408</u>

Real Estate Tax History	1995	71,525
(prior year page 10)	1996	107,638
	1997	112,256
1999 tax payments	1998	112,260
(per tax bill) var		<u>10</u>

CENSUS INFORMATION (days)		CENSUS SUMMARY	
Private Skilled	401	Private Skilled	5,349
Paid Bedhold	2	Private Intermediate	17,100
Non-paid Bedhold	0	Sheltered Care	0
Paid Discharge	0	Medicare	5,262
Private Intermediate	17,100	Medicaid	9,470
Paid Bedhold	504	V.A.	0
Non-paid Bedhold	0	Total Patient Day:	<u>37,181</u>
Paid Discharge	0	Bed hold Days	660
Private Other	4,948	Total Days	<u>37,841</u>
Paid Bedhold	152		
Paid Discharge	0		
Sheltered Care	0		
Paid Bedhold	0		
Paid Discharge	0		
Medicare	5,262		
Paid Bedhold	0		
Non-paid Bedhold	0	Medicaid Allocation:	
Paid Discharge	0	Skilled (1/3)	<u>3,157</u>
Medicaid	9,470	Intermediate (2/3)	<u>6,313</u>
Paid Bedhold	2		
Non-paid Bedhold	0	Medicaid Paid Bedhold	<u>2</u>
Paid Discharge	0		
V.A. days	0		
Total Days	<u>37,841</u>		

CONSULTANT SERVICES		Pg 20, Ln/Amt	
2,318	10-3 4400	900	39 900
0	4425	0	46 0
	4455	1,418	37 1,418
17,904	10A-3 4550	0	40 17,904
0	4551	0	40
	4552	0	40
	4575	0	41 0
	4576	0	41
	4577	0	41
	4600	0	43 0
	4601	0	43
	4602	0	43
	4650	17,904	40
	Total	<u>20,222</u>	<u>20,222</u>

FACILITY NAME: Parkway Manor BEGINNING: 1/1/01
 ID#: 0040972 ENDING: 12/31/01

RELATED PARTIES
DATA INPUT SHEET

1	Balance Sheet	Grouping Code	Facility \$ Amount	RFMS Mngmnt Amount	Lessor Amount	Consolidated Total
	Cash	A1	11,402	81,255	0	92,657
	Patient Deposits	A2	960	0	0	960
	Accounts Receivable	A3	552,139	425,795	0	977,934
	Prepaid Insurance	A6	78,485	27,491	0	105,976
	Other Prepaid Exp	A7	0	0	0	0
	Related Party Rec'ble	A8	0	1,574,571	0	1,574,571
	Interdivision Receivable	A9	1,935,163	0	0	1,935,163
	Interest Receivable	A9a	0	0	0	0
	Long-term Investments	B12	0	104,078	0	104,078
	Land	B13	0	0	244,382	244,382
	Buildings	B14	0	0	3,063,499	3,063,499
	Leasehold Improve	B15	96,966	134,810	138,120	369,896
	Equipment	B16	118,332	622,295	503,500	1,244,127
	Accum Depreciation	B17	(133,623)	(601,776)	(1,042,944)	(1,778,343)
	Deferred Maintenance	B18	0	0	0	0
	Org & Pre-Op Costs	B19	0	0	0	0
	Accum Amortization	B20	0	0	0	0
	Loan Financing Costs	B23a	0	0	0	0
	Leasehold Deposit	B23b	0	0	0	0
	Total Assets		2,659,824	2,368,519	2,906,557	7,934,900
	Accounts Payable	C26	82,043	34,290	0	116,333
	A/P-Patient Deposits	C28	960	0	0	960
	Short-Term Notes Pay	C29	0	0	0	0
	Accrued Salaries	C30	178,163	125,952	0	304,115
	Accrued Taxes	C31	2,691	0	0	2,691
	AccrRealEstateTax	C32	118,000	5,886	0	123,886
	Accrued Interest	C33	0	0	16,598	16,598
	Interdivision Payable	C36	0	0	0	0
	Other Current Liab	C37	0	0	0	0
	Mortgage Payable	D40	0	0	2,990,712	2,990,712
	Patient Deposits	D44	102,328	0	0	102,328
	Retained Earnings	E1	1,613,605	2,202,391	(100,753)	3,715,243
	Distributions	E13	0	0	0	0
	Transfers	E18	0	0	0	0
	Total Liab & Equity		2,097,790	2,368,519	2,906,557	7,372,866
	Net Income(Loss)		562,034	0	0	562,034
2	Lessor - Interest Expense				<u>209,083</u>	
	Lessor - Loan Fee Amortization				<u>4,247</u>	

FACILITY NAME: Parkway Manor
 ID #: 0040972

BEGINNING: 1/1/01
 ENDING: 12/31/01

ATTACHED SCHEDULE I

VII. RELATED NURSING HOMES

<u>FACILITY NAME</u>	<u>CITY</u>
Care Center of Abingdon	Abingdon
Centralia Manor	Centralia
Jerseyville Manor	Jerseyville
Lawrenceville Manor	Lawrenceville
Leroy Manor	Leroy
Maryville Manor	Maryville
Parkway Manor	Marion
Pekin Manor	Pekin
Pittsfield Manor	Pittsfield
Seminary Manor	Galesburg
Shelbyville Manor	Shelbyville

<u>RECLASSIFICATION ENTRY</u>	Schedule and Ledger Line #	Total Per General Ledger (Column 4)	Reclass Increase or (Decrease) (Column 5)	Reclassified Total (Column 6)
(1) To Allocate a % of Vehicle Expenses To Program				
Program Transportation	V-14	165	510	675
Other Admin. Staff Transportation	V-25	1,019	(510)	509

SCHEDULE V - LINE 25 - OTHER ADMIN. STAFF TRANSPORTATION

Care Related Vehicle Expenses:	
Fuel and miscellaneous supplies	614
Repairs and maintenance	405
Total vehicle expenses	<u>1,019</u>

FACILITY NAME: Parkway Manor
ID #: 0040972

BEGINNING: 1/1/01
ENDING: 12/31/01

ATTACHED SCHEDULE II **Bed Allocation**

FACILITY NAME: Parkway Manor BEGINNING: 1/1/01
 ID#: 0040972 ENDING: 12/31/01

ATTACHED SCHEDULE III Allocation of Related Party Administrative Service Costs

**SUMMARY SCHEDULE
 (See attached detail schedule)**

Sch. V		Salaries	Other	Total
Line #				
1	Dietary			0
2	Food Purchase			0
3	Housekeeping			0
4	Laundry			0
5	Heat & Other Utilities		323	323
6	Maintenance		463	463
7	Other			0
9	Medical Director			0
10	Nursing & Med Records			0
10A	Therapy			0
11	Activities			0
12	Social Services			0
13	Nurse Aide Training			0
14	Program Transportation			0
15	Other			0
17	Administrative	81,797		81,797
18	Directors Fees			0
19	Professional Services		2,861	2,861
20	Fees, Subs. & Pro.		14	14
21	Clerical & General		7,005	7,005
22	Employee Ben. & P/R		13,025	13,025
23	Inservice Training & Ed.			0
24	Travel & Seminar		3,880	3,880
25	Admin. Staff Transp.		3,172	3,172
26	Insurance		233	233
27	Other			0
30	Depreciation		3,023	3,023
31	Amortization of Pre-Op.			0
32	Interest		150	150
33	Real Estate Taxes		285	285
34	Rent-Facility & Grounds		3,876	3,876
35	Rent-Equip. & Vehicles		650	650
36	Other - Amortization			0
TOTALS		<u>81,797</u>	<u>38,960</u>	120,757

19 Amount per G/L - administrative services recorded as professional fees (156,000)
 Net adjustment required (35,243)

FACILITY NAME: Parkway Manor BEGINNING: 1/1/01
 ID#: 0040972 ENDING: 12/31/01

ATTACHED SCHEDULE III Allocation of Related Party Administrative Service Costs
DETAIL SCHEDULE

ALLOCATION FACTORS	Total	Facility	Allocation
	Y-T-D Beds	Y-T-D Beds	Percentage
ALL FACILITIES	33,156	1,428	4.3069%
NURSING HOME FACILITIES	16,128	1,428	8.8542%

ALL FACILITIES:	Total	Non-	Adjusted	Allocated	Schedule
	Costs	Allowable	Costs	Costs	& Line
	Incurred	Costs			Reference
Salaries - Owner	200,000		200,000	8,614	V-17
Salaries and wages	816,159	49,212	766,947	33,032	V-17
Advertising	317		317	14	V-20
Insurance	5,401		5,401	233	V-26
Payroll taxes & other benefits - Owner	37,441	23,970	13,471	580	V-22
Payroll taxes & other benefits	156,214	10,580	145,634	6,272	V-22
Utilities	8,579	1,089	7,490	323	V-5
Telephone	35,472		35,472	1,528	V-21
Building rental	90,000		90,000	3,876	V-34
Depreciation	70,200		70,200	3,023	V-30
Interest	3,481		3,481	150	V-32
Legal fees	13,898	6,364	7,534	324	V-19
Accounting fees	92,167	50,765	41,402	1,783	V-19
Outside management consultants	17,500		17,500	754	V-19
Supplies	100,911		100,911	4,346	V-21
Airplane & vehicle rental	15,098		15,098	650	V-35
Vehicle expense	15,156		15,156	653	V-25
Travel reimbursements	38,443	34,103	4,340	187	V-24
Meal expense	15,657	8,137	7,520	324	V-24
Training	4,985	2,350	2,635	113	V-24
Real estate taxes	6,612		6,612	285	V-33
Building & equipment maintenance	10,752		10,752	463	V-6
Other	28,403	28,403	0	0	V-21
Printing	4,030	48	3,982	172	V-21
SUBTOTALS	1,786,876	215,021	1,571,855	67,699	
NURSING HOME FACILITIES:					
Salaries and wages	453,471		453,471	40,151	V-17
Insurance	0		0	0	V-26
Payroll taxes & other benefits	69,718		69,718	6,173	V-22
Telephone	10,835		10,835	959	V-21
Vehicle expense	28,445		28,445	2,519	V-25
Vehicle lease	0		0	0	V-35
Travel reimbursements	21,672		21,672	1,919	V-24
Meal expense	2,792		2,792	247	V-24
Training	12,306		12,306	1,090	V-24
SUBTOTALS	599,239	0	599,239	53,058	
TOTALS	2,386,115	215,021	2,171,094	120,757	

SUMMARY SCHEDULE

Salaries - Administrative	81,797	V-17
Heat & Other Utilities	323	V-5
Maintenance	463	V-6
Professional Services	2,861	V-19
Fees, Subscriptions & Promotion	14	V-20
Clerical & General Office Exp.	7,005	V-21
Employee Benefits & P/R Taxes	13,025	V-22
Travel & Seminar	3,880	V-24
Other Admin. Staff Transp.	3,172	V-25
Insurance	233	V-26
Depreciation	3,023	V-30
Interest	150	V-32
Real Estate Taxes	285	V-33
Rent - Facility	3,876	V-34
Rent - Equipment & Vehicles	650	V-35
	38,960	
	120,757	

FACILITY NAME: Parkway Manor BEGINNING: 1/1/01
 ID#: 0040972 ENDING: 12/31/01

ATTACHED SCHEDULE IV **Related Party Cost Adjustment
Facility Rent**

Cost to Related Party Lessor:		
Depreciation (Reported on Sch. XI)	154,510	V-30
Interest	209,083	V-32
Loan Fee Amortization	<u>4,247</u>	V-36
Total lessor cost	367,840	
Cost Per General Ledger - Facility Rent	492,660	V-34
Cost Adjustment Required	<u>(124,820)</u>	

Page 5, Line 10, Interest and Other Investment Income Adjustment

Allocation of Investment Income
(Centralia Manor a/c #1929 & 1930)

Facility	Beds/Units	%	Allocated	Adjust
Centralia Manor	120	9.4637%	41,742	
Jerseyville Manor	84	6.6246%	29,219	
Lawrenceville Manor	123	9.7003%	42,786	
Leroy Manor	96	7.5710%	33,394	
Maryville Manor	120	9.4637%	41,742	
Parkway Manor	119	9.3849%	41,394	41,394
Pekin Manor	151	11.9085%	52,525	
Pittsfield Manor	105	8.2808%	36,524	
Shelbyville Manor	131	10.3312%	45,568	
Centralia Estates	39	3.0757%	13,566	
Liberty Estates	59	4.6530%	20,523	
Parkway Estates	42	3.3123%	14,610	
Pekin Estates	79	6.2303%	27,480	
Totals	<u>1,268</u>	<u>100%</u>	<u>441,074</u>	

Interest and Other Investment Income (Page 19, Line 25)	201
Required Adjustment (Page 5, Line 10)	<u>41,595</u>

FACILITY NAME: Parkway Manor
ID #: 0040972

BEGINNING: 1/1/01
ENDING: 12/31/01

ATTACHED SCHEDULE V

PAGE 19, XVII. INCOME STATEMENT

Federal Income Tax Return Reconciliation:

Income (loss) before income taxes (Line 41)		562,034
Nondeductible expenses:		
50% meal exclusion	16	
Fines and penalties	0	
Lobbying expenses	476	
	<hr/>	492
Timing differences:		
Depreciation expense - tax basis	(16,221)	
Depreciation expense - book basis	17,768	
Accrued vacation exp. - prior year	(65,755)	
Accrued vacation exp. - current year	64,600	
	<hr/>	392
		<hr/>
Taxable income (loss)		562,918

FACILITY NAME: Parkway Manor
ID#: 0040972

BEGINNING: 1/1/01
ENDING: 12/31/01

ATTACHED SCHEDULE VI

SCHEDULE V - COST CENTER EXPENSES

LINE 27 - OTHER:

Bad Debts	4,950
Lobbying	<u>476</u>
Total	<u>5,426</u>

ATTACHED SCHEDULE VII

SCHEDULE VI - ADJUSTMENT DETAIL

LINE 29 - OTHER:

Out-of-state Training	V-24	1,276
Lobbying	V-27	476
Activity fund income	V-11	<u>0</u>
Total		<u>1,752</u>

ATTACHED SCHEDULE VIII

Page 17, XV. BALANCE SHEET

	Operating	After Consolidated
Line 9, Other Current Assets:		
Interdivision Receivable	1,935,163	1,935,163
Interest Receivable	<u>0</u>	<u>0</u>
Total	<u>1,935,163</u>	<u>1,935,163</u>

ATTACHED SCHEDULE IX

Page 18, XVI. STATEMENT OF CHANGES IN EQUITY

Line 4, Restatements:	
Uncollectible patient accounts	0
Medicare cost report settlements	11,403
Related party accrued interest income	0
Workers' comp insurance	0
Miscellaneous	0
Illinois replacement tax	<u>0</u>
Total	<u>11,403</u>

Restatements are year end adjustments which were made subsequent to the preparation of the Medicaid cost report for the prior year. The equity balance at the beginning of the year, restated by the above adjustments, agrees with the financial statements.

FACILITY NAME: Parkway Manor
ID#: 0040972

BEGINNING: 1/1/01
ENDING: 12/31/01