

		FOR OHF USE				

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

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>0021428</u></p> <p>Facility Name: <u>Walker Nursing Home</u></p> <p>Address: <u>530 East Beardstown St.</u> <u>Virginia</u> <u>62691</u> Number City Zip Code</p> <p>County: <u>Cass</u></p> <p>Telephone Number: <u>(217) 452-3218</u> Fax # <u>(217) 452-7746</u></p> <p>IDPA ID Number: <u>37-0960906</u></p> <p>Date of Initial License for Current Owners: <u>1/1/1955</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>Mark Tomaw</u> Telephone Number: <u>(217) 789-7700</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>10/1/01</u> to <u>9/30/02</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 data-bbox="1144 673 1281 828">Officer or Administrator of Provider</td> <td data-bbox="1281 673 1921 747">(Signed) _____ (Date) _____ (Type or Print Name) <u>George W. White or Mary Ann White</u></td> </tr> <tr> <td data-bbox="1144 747 1281 828"></td> <td data-bbox="1281 747 1921 828">(Title) <u>Co-Administrators</u></td> </tr> <tr> <td data-bbox="1144 828 1281 1039">Paid Preparer</td> <td data-bbox="1281 828 1921 1039">(Signed) <u>See Attached Independent Accountant's Report</u> (Date) _____ (Print Name and Title) <u>McGladrey & Pullen, LLP P.O. Box 159</u> (Firm Name & Address) <u>15 S. Old State Cap. Plaza, Suite 200, Springfield, IL 62705</u> (Telephone) <u>(217) 789-7700</u> Fax # <u>(217) 753-1654</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>George W. White or Mary Ann White</u>		(Title) <u>Co-Administrators</u>	Paid Preparer	(Signed) <u>See Attached Independent Accountant's Report</u> (Date) _____ (Print Name and Title) <u>McGladrey & Pullen, LLP P.O. Box 159</u> (Firm Name & Address) <u>15 S. Old State Cap. Plaza, Suite 200, Springfield, IL 62705</u> (Telephone) <u>(217) 789-7700</u> Fax # <u>(217) 753-1654</u>
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Home

0021428 Report Period Beginning: 10/1/01 Ending: 9/30/02

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	3 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		2 Public Aid Recipient	Private Pay	4 Other		
8	SNF	366	677		1,043	8
9	SNF/PED					9
10	ICF	12,084	7,358		19,442	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,450	8,035		20,485	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.05%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

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 _____ NO

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 9/30/2002 Fiscal Year: 9/30/2002
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/1/01 Ending: 9/30/02

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	91,079	1,557	5,824	98,460		98,460		98,460		1
2	Food Purchase		147,376		147,376		147,376		147,376		2
3	Housekeeping	38,795	7,866		46,661		46,661		46,661		3
4	Laundry	32,756	204	2,275	35,235		35,235		35,235		4
5	Heat and Other Utilities			60,711	60,711		60,711		60,711		5
6	Maintenance	41,004	17,551	24,361	82,916		82,916		82,916		6
7	Other (specify):*										7
8	TOTAL General Services	203,634	174,554	93,171	471,359		471,359		471,359		8
	B. Health Care and Programs										
9	Medical Director			2,200	2,200		2,200		2,200		9
10	Nursing and Medical Records	637,896	41,169	2,981	682,046		682,046		682,046		10
10a	Therapy			1,325	1,325		1,325		1,325		10a
11	Activities	17,323	4,615		21,938		21,938		21,938		11
12	Social Services	21,573			21,573		21,573		21,573		12
13	Nurse Aide Training										13
14	Program Transportation			2,857	2,857		2,857		2,857		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	676,792	45,784	9,363	731,939		731,939		731,939		16
	C. General Administration										
17	Administrative	102,403			102,403		102,403		102,403		17
18	Directors Fees										18
19	Professional Services			62,854	62,854		62,854		62,854		19
20	Dues, Fees, Subscriptions & Promotions			7,016	7,016		7,016	(836)	6,180		20
21	Clerical & General Office Expenses	39,095	15,254	8,910	63,259		63,259		63,259		21
22	Employee Benefits & Payroll Taxes			128,097	128,097		128,097		128,097		22
23	Inservice Training & Education			371	371		371		371		23
24	Travel and Seminar			2,913	2,913		2,913		2,913		24
25	Other Admin. Staff Transportation			18,627	18,627		18,627		18,627		25
26	Insurance-Prop.Liab.Malpractice			84,490	84,490		84,490		84,490		26
27	Other (specify):* See attached schedule			34,780	34,780		34,780	(23,600)	11,180		27
28	TOTAL General Administration	141,498	15,254	348,058	504,810		504,810	(24,436)	480,374		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,021,924	235,592	450,592	1,708,108		1,708,108	(24,436)	1,683,672		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Walker Nursing Home

#0021428

Report Period Beginning:

10/1/01

Ending:

9/30/02

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			43,093	43,093		43,093	31,767	74,860			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			22,854	22,854		22,854		22,854			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			2,197	2,197		2,197		2,197			35
36	Other (specify):*											36
37	TOTAL Ownership			68,144	68,144		68,144	31,767	99,911			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			738	738		738		738			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			40,163	40,163		40,163		40,163			42
43	Other (specify):* State Income tax			2,270	2,270		2,270		2,270			43
44	TOTAL Special Cost Centers			43,171	43,171		43,171		43,171			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,021,924	235,592	561,907	1,819,423		1,819,423	7,331	1,826,754			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Home

0021428

Report Period Beginning: 10/1/01

Ending: 9/30/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	31,767	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	(1,060)	27		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions		30		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,740)	27		18
19	Entertainment	(15,956)	27		19
20	Contributions	(4,844)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(340)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(496)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 7,331		\$	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			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 7,331		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Walker Nursing Home

ID# 0021428
 Report Period Beginning: 10/1/01
 Ending: 9/30/02

Sch. V Line Reference

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
17			17
18			18
19			19
20			20
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26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Walker Nursing Home

0021428

Report Period Beginning:

10/1/01

Ending:

9/30/02

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	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	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(836)	0	0	0	0	0	0	0	0	0	0	(836)	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):*	(23,600)	0	0	0	0	0	0	0	0	0	0	(23,600)	27
28	TOTAL General Administration	(24,436)	0	0	0	0	0	0	0	0	0	0	(24,436)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(24,436)	0	0	0	0	0	0	0	0	0	0	(24,436)	29

Facility Name & ID Number Walker Nursing Home

0021428

Report Period Beginning:

10/1/01

Ending:

9/30/02

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%					
Mary Ann White	50%	None		None		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/1/01 Ending: 9/30/02

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	Mary Ann White	President	Co-Administrator	50.00	0	50	40.00	Salary	14,743	2
3			Office Manager				60.00	Salary	22,114	3
4										4
5	George W. White	Vice-President	Co-Administrator	50.00	0	50	45.00	Salary	19,736	5
6			Maintenance				55.00	Salary	24,121	6
7										7
8	Bryan White	None	Asst. Admin	0.00	0	40	80.00	Salary	38,022	8
9			Clerical				20.00	Salary	9,505	9
10	Rachel White	None	Asst. Admin	0.00	0	40	80.00	Salary	29,902	10
11			Clerical				20.00	Salary	7,476	11
12										12
13								TOTAL	\$ 165,619	13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME. ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/1/01 Ending: 9/30/02

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

Facility Name & ID Number Walker Nursing Home

0021428

Report Period Beginning:

10/1/01

Ending:

9/30/02

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											2								
3											3								
4											4								
5											5								
	Working Capital																		
6											6								
7											7								
8											8								
9	TOTAL Facility Related					\$	\$			\$	9								
	B. Non-Facility Related*																		
10											10								
11											11								
12											12								
13											13								
14	TOTAL Non-Facility Related					\$	\$			\$	14								
15	TOTALS (line 9+line14)					\$	\$			\$	15								

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

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

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

Facility Name & ID Number Walker Nursing Home

0021428 Report Period Beginning: 10/1/01 Ending: 9/30/02

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 statement and bill must accompany the cost report.				
1.	Real Estate Tax accrual used on 2001 report.			\$	15,502	1
2.	Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	22,510	2
3.	Under or (over) accrual (line 2 minus line 1).			\$	7,008	3
4.	Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	15,576	4
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	22,584	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		1997	18,687	8		
		1998	19,112	9		
		1999	19,539	10		
		2000	20,670	11		
		2001	22,061	12		
Real taxes is based upon prior taxes of approximately 9/12th.						
					FOR OHF USE ONLY	
		13	FROM R. E. TAX STATEMENT FOR 2001	\$		13
		14	PLUS APPEAL COST FROM LINE 5	\$		14
		15	LESS REFUND FROM LINE 6	\$		15
		16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 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 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 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 2002 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.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Walker Nursing Home COUNTY Cass

FACILITY IDPH LICENSE NUMBER 0021428

CONTACT PERSON REGARDING THIS REPORT Mark Tomaw

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2001 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 2001.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>09-033-009-00</u>	<u>Lot</u>	\$ <u>702.76</u>	\$ <u>702.76</u>
2. <u>11-087-007-00</u>	<u>Lot</u>	\$ <u>16,498.36</u>	\$ <u>16,498.36</u>
3. <u>11-052-009-00</u>	<u>Lot</u>	\$ <u>553.02</u>	\$ <u>553.02</u>
4. <u>11-076-003-00</u>	<u>Lot</u>	\$ <u>1,459.18</u>	\$ <u>1,459.18</u>
5. <u>11-064-010-01</u>	<u>Lot</u>	\$ <u>1,297.36</u>	\$ <u>1,297.36</u>
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>20,510.68</u>	\$ <u>20,510.68</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 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Walker Nursing Home# 0021428 Report Period Beginning:10/1/01 Ending:9/30/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,040 B. General Construction Type: Exterior Brick Frame Wood & Steel 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).

NoneF. 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:

A. Land.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Home

0021428

Report Period Beginning:

10/1/01

Ending:

9/30/02

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 OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	20	1972	1972	\$ 130,523	\$	30	\$	\$	\$ 130,523	4
5	30	1977	1977	363,607		30	12,110	12,110	303,000	5
6	5	1981	1981	79,226		30	2,641	2,641	57,392	6
7	16	1985	1985	399,762	19,988	30	13,326	(6,662)	226,540	7
8										8
Improvement Type**										
9	Fully Depreciated Improvements	1974		900					900	9
10		1975		200					200	10
11		1983		533					533	11
12	Building Improvements	1977		2,889		Various	23	23	2,889	12
13		1982		552		Various	20	20	552	13
14		1984		11,510		Various	576	576	10,751	14
15		1985		70,113	563	Various	748	185	67,909	15
16		1986		7,764	404	Various	313	(91)	5,013	16
17		1988		2,015	64	Various	66	2	941	17
18		1990		2,480		Various	165	165	2,105	18
19		1991		23,204	684	Various	817	133	8,562	19
20		1992		45,807	1,455	Various	1,502	47	16,263	20
21		1993		11,951	364	Various	374	10	3,428	21
22		1995		4,939	342	Various	432	90	3,214	22
23		1996		6,289	561	Various	613	52	4,106	23
24	Driveway	1997		14,601	876	18	876		4,526	24
25	New Doorway	1997		4,316	110	39	110		575	25
26	Interior Remodeling	1997		7,773	199	39	199		1,054	26
27	Storage Building	1997		29,195	748	39	748		4,051	27
28	Air conditioner	1997		4,369	112	39	112		583	28
29	Insulation	1997		3,400	87	40	87		453	29
30	New roof	1998		38,739	993	40	968	(25)	3,954	30
31	Roof repair	1999		3,997	102	40	102		405	31
32	Fire valves	1999		2,869	74	40	74		286	32
33	Windows	1999		2,066	53	40	53		183	33
34	Water heater	2000		4,528	113	40	226	113	679	34
35	Shower faucets	2000		1,550	39	40	78	39	233	35
36	Door Locks	2001		1,500	25	10	150	125	75	36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Home

0021428

Report Period Beginning:

10/1/01

Ending:

9/30/02

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)		\$ 1,283,167	\$ 27,956		\$ 37,509	\$ 9,553	\$ 861,878		70

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	\$ 278,945	\$ 12,164	\$ 28,733	\$ 16,569	3-39years	\$ 278,945	71
72	Current Year Purchases	23,438	1,501	1,891	390	5-10years		72
73	Fully Depreciated Assets	331,179					384,766	73
74								74
75	TOTALS	\$ 633,562	\$ 13,665	\$ 30,624	\$ 16,959		\$ 663,711	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	1993 GMC Van	1983	\$ 17,000	\$	\$	\$	4	\$ 17,000	76
77	Patient Care	1987 Handicapped Bus	1998	6,800	744	1,275	531	4	6,800	77
78	Patient Care	Handicap Bus	2002	43,614	727	5,452	4,725	4	5,452	78
79	Patient Care									79
80	TOTALS			\$ 67,414	\$ 1,471	\$ 6,727	\$ 5,256		\$ 29,252	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)	\$ 2,018,747	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 43,092	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 74,860	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 31,768	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,554,841	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	1996 Dodge Ram	\$ 33,608	\$ 1,775	\$ 18,010	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 33,608	\$ 1,775	\$ 18,010	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: _____
 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 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			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.	<u> /2003 </u>	\$ _____
13.	<u> /2004 </u>	\$ _____
14.	<u> /2005 </u>	\$ _____

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			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

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 _____</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.

\$

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 prescripts							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 Walker Nursing Home

0021428

Report Period Beginning: 10/1/01

Ending:

9/30/02

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/02

(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	\$ 74,389	\$	1
2 Cash-Patient Deposits			2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance)	203,517		3
4 Supply Inventory (priced at)			4
5 Short-Term Investments	253,487		5
6 Prepaid Insurance			6
7 Other Prepaid Expenses			7
8 Accounts Receivable (owners or related parties)			8
9 Other(specify): <u>Loans to Officers</u>	38,528		9
10 TOTAL Current Assets (sum of lines 1 thru 9)	\$ 569,922	\$	10
B. Long-Term Assets			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land	34,604		13
14 Buildings, at Historical Cost	1,283,166		14
15 Leasehold Improvements, at Historical Cost			15
16 Equipment, at Historical Cost	734,887		16
17 Accumulated Depreciation (book methods)	(1,703,525)		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>Income tax deposits</u>	21,346		23
24 TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 370,478	\$	24
25 TOTAL ASSETS (sum of lines 10 and 24)	\$ 940,400	\$	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$ 28,777	\$	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits			28
29 Short-Term Notes Payable			29
30 Accrued Salaries Payable	63,456		30
31 Accrued Taxes Payable (excluding real estate taxes)	2,531		31
32 Accrued Real Estate Taxes(Sch.IX-B)	16,277		32
33 Accrued Interest Payable			33
34 Deferred Compensation			34
35 Federal and State Income Taxes			35
Other Current Liabilities(specify):			
36			36
37			37
38 TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 111,042	\$	38
D. Long-Term Liabilities			
39 Long-Term Notes Payable			39
40 Mortgage Payable			40
41 Bonds Payable			41
42 Deferred Compensation			42
Other Long-Term Liabilities(specify):			
43			43
44			44
45 TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46 TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 111,042	\$	46
47 TOTAL EQUITY(page 18, line 24)	\$ 829,358	\$	47
48 TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 940,400	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 795,779	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 795,779	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	168,370	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	(131,038)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)	(3,752)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 33,579	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 829,358	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,985,171	1
2	Discounts and Allowances for all Levels	(8,934)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,976,237	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	11,556	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 11,556	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,987,792	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	471,359	31
32	Health Care	731,939	32
33	General Administration	504,810	33
B. Capital Expense			
34	Ownership	68,144	34
C. Ancillary Expense			
35	Special Cost Centers	738	35
36	Provider Participation Fee	40,163	36
D. Other Expenses (specify):			
37	State Income Taxes	2,270	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,819,423	40
41	Income before Income Taxes (line 30 minus line 40)**	168,370	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 168,370	43

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

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

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

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

Facility Name & ID Number Walker Nursing Home

0021428

Report Period Beginning: 10/1/01

Ending:

9/30/02

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	2,095	\$ 56,213	\$ 25.79	1
2	Assistant Director of Nursing				2
3	Registered Nurses	3,683	76,329	20.11	3
4	Licensed Practical Nurses	12,193	208,830	16.22	4
5	Nurse Aides & Orderlies	29,026	296,523	9.73	5
6	Nurse Aide Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director	1,408	17,323	12.30	9
10	Activity Assistants				10
11	Social Service Workers	1,845	21,573	11.21	11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook	2,262	22,428	9.23	14
15	Cook Helpers/Assistants	8,285	68,651	7.85	15
16	Dishwashers				16
17	Maintenance Workers	3,003	41,006	8.85	17
18	Housekeepers	6,600	38,795	5.67	18
19	Laundry	4,198	32,756	7.49	19
20	Administrator	2,210	34,478	15.60	20
21	Assistant Administrator	3,328	67,924	19.57	21
22	Other Administrative				22
23	Office Manager	1,560	22,114	14.18	23
24	Clerical	832	16,981	17.52	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)	82,528	\$ 1,021,924 *	\$ 11.62	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	208	\$ 5,824	1-3	35
36	Medical Director	22	2,200	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	24	1,325	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	254	\$ 9,349		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,682	\$ 30,558	10-3	50
51	Licensed Practical Nurses	238	6,333	10-3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	1,920	\$ 36,891		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Home

0021428

Report Period Beginning: 10/1/01

Ending: 9/30/02

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	
Mary Ann White	Co-Administrator	50.00	\$ 14,743	Workers' Compensation Insurance	\$ 0	IDPH License Fee	\$ 0	
George W. White	Co-Administrator	50.00	19,736	Unemployment Compensation Insurance	9,095	Advertising: Employee Recruitment	1,795	
Bryan White	Asst. Administrator	0.00	38,022	FICA Taxes	76,204	Health Care Worker Background Check	108	
Rachel White	Asst. Administrator	0.00	29,902	Employee Health Insurance	40,141	(Indicate # of checks performed 9)		
				Employee Meals		Dues	2,473	
				Illinois Municipal Retirement Fund (IMRF)*		Licenses & Fees	40	
				Misc Employee Benefits	2,657	Subscriptions	1,764	
						Promotional Advertising	340	
						Yellow Page Advertising	496	
TOTAL (agree to Schedule V, line 17, col. 1)						Less: Public Relations Expense	()	
(List each licensed administrator separately.)			\$ 102,403			Non-allowable advertising	(340)	
						Yellow page advertising	(496)	
B. Administrative - Other						TOTAL (agree to Sch. V, line 20, col. 8)		
Description			Amount		\$ 128,097			
			\$					
TOTAL (agree to Schedule V, line 17, col. 3)			\$					
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
McGladrey & Pullen	Accounting Fees		\$ 15,400			\$	Out-of-State Travel	\$
Ravin, Myers & Hanken	Legal Fees		175					
Londrigan, Potter & Randle	Legal Fees		198				In-State Travel	
Quorum Consulting	401K Admin. Fees		2,400				Lodging	602
Integrity Staffing	Misc		16,631					
Medical Staffing Network	Misc		20,260				Seminar Expense	1,432
Ramirez Consulting	Misc		5,525				Activity Director Training	164
Enloe Drugs	Misc		1,650				Social Services Training	420
Other Misc	Misc		615				Nurse Training	295
							Entertainment Expense	()
							(agree to Sch. V,	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	line 24, col. 8)	\$ 2,913
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 62,854					

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

1	2	3	4	5										
				6										
1	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year									
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	
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 Walker Nursing Home

0021428

Report Period Beginning:

10/1/01

Ending:

9/30/02

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. IHCA \$2,681, INHAA \$485
- (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? 7 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 2,151 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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 40,163
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes-Pg. 7 If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department 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? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100%
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT