



Facility Name & ID Number Ellner Terrace

# 0036327 Report Period Beginning: 7/1/99 Ending: 6/30/00

**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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,856</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,856</u>	7

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

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

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

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

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

**I. On what date did you start providing long term care at this location?**  
 Date started 06/01/90

**J. Was the facility purchased or leased after January 1, 1978?**  
 YES  Date 06/01/90 NO

**K. Was the facility certified for Medicare during the reporting year?**  
 YES  NO  If YES, enter number of beds certified N/A and days of care provided 0

Medicare Intermediary N/A

**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	Other		
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	<u>4,983</u>			<u>4,983</u>	13
14	TOTALS	<u>4,983</u>			<u>4,983</u>	14

**IV. ACCOUNTING BASIS**  
 ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 6/30/00 Fiscal Year: 6/30/00  
 \* All facilities other than governmental must report on the accrual basis.

**C. Percent Occupancy.** (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.09%

## STATE OF ILLINOIS

Page 3  
6/30/00

Facility Name &amp; ID Number Ellner Terrace

# 0036327

Report Period Beginning: 7/1/99

Ending: 6/30/00

## 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
	<b>A. General Services</b>										
1	Dietary	13,882	761	840	15,483		15,483		15,483		1
2	Food Purchase		22,535		22,535		22,535	(2,969)	19,566		2
3	Housekeeping		1,713		1,713		1,713		1,713		3
4	Laundry		1,299		1,299		1,299		1,299		4
5	Heat and Other Utilities			9,190	9,190		9,190	43	9,233		5
6	Maintenance	11,500		7,576	19,076		19,076	727	19,803		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>25,382</b>	<b>26,308</b>	<b>17,606</b>	<b>69,296</b>		<b>69,296</b>	<b>(2,199)</b>	<b>67,097</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			1,200	1,200		1,200		1,200		9
10	Nursing and Medical Records	94,654	2,960	2,494	100,108		100,108	289	100,397		10
10a	Therapy			746	746		746		746		10a
11	Activities		2,775	62	2,837		2,837	1,213	4,050		11
12	Social Services			1,855	1,855		1,855		1,855		12
13	Nurse Aide Training	6,610	225	1,620	8,455		8,455		8,455		13
14	Program Transportation			2,634	2,634		2,634		2,634		14
15	Other (specify):* <b>Routine Dental</b>			826	826		826		826		15
16	<b>TOTAL Health Care and Programs</b>	<b>101,264</b>	<b>5,960</b>	<b>11,437</b>	<b>118,661</b>		<b>118,661</b>	<b>1,502</b>	<b>120,163</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	29,140		35,985	65,125		65,125	(35,985)	29,140		17
18	Directors Fees							2,764	2,764		18
19	Professional Services			48,484	48,484		48,484	10,218	58,702		19
20	Dues, Fees, Subscriptions & Promotions			1,806	1,806		1,806	432	2,238		20
21	Clerical & General Office Expenses	19,524	3,558	4,694	27,776		27,776	8,902	36,678		21
22	Employee Benefits & Payroll Taxes			18,207	18,207		18,207	20,561	38,768		22
23	Inservice Training & Education			345	345		345	799	1,144		23
24	Travel and Seminar			703	703		703	1,979	2,682		24
25	Other Admin. Staff Transportation			847	847		847	114	961		25
26	Insurance-Prop.Liab.Malpractice							4,306	4,306		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>48,664</b>	<b>3,558</b>	<b>111,071</b>	<b>163,293</b>		<b>163,293</b>	<b>14,090</b>	<b>177,383</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>175,310</b>	<b>35,826</b>	<b>140,114</b>	<b>351,250</b>		<b>351,250</b>	<b>13,393</b>	<b>364,643</b>		<b>29</b>

\*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.

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

Facility Name &amp; ID Number

Ellner Terrace

#0036327

Report Period Beginning:

7/1/99

Ending:

6/30/00

## 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
	<b>D. Ownership</b>										
30	Depreciation			3,191	3,191		3,191	741	3,932		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			839	839		839	4,819	5,658		32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds			63,926	63,926		63,926	1,386	65,312		34
35	Rent-Equipment & Vehicles			11,640	11,640		11,640	1,506	13,146		35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			79,596	79,596		79,596	8,452	88,048		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers			1,469	1,469		1,469		1,469		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			21,215	21,215		21,215	7,072	28,287		42
43	Other (specify):* <b>Nonallowable costs</b>			149,904	149,904		149,904	(149,904)			43
44	<b>TOTAL Special Cost Centers</b>			172,588	172,588		172,588	(142,832)	29,756		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	175,310	35,826	392,298	603,434		603,434	(120,987)	482,447		45

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ellner Terrace

# 0036327

Report Period Beginning: 7/1/99

Ending: 6/30/00

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	(149,201)	43		3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(363)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(118)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(700)	32		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				24
25	Fund Raising, Advertising and Promotional	(340)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>Offset miscellaneous income</u>	31	21		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (150,691)		\$	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)	29,704		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 29,704		36
37	<b>TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)</b>	\$ (120,987)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Ellner Terrace

ID# 0036327

Report Period Beginning: 7/1/99

Ending: 6/30/00

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	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
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49			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			70
71			71
72			72
73			73
74			74
75			75
76			76
77			77
78			78
79			79
80			80
81			81
82			82
83			83
84			84
85			85
86			86
87			87
88			88
89			89
90	Total	0	90

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
Residential Centers, Inc. - See attached Schedule 7A	100.00%	See attached Related Party Schedule		See attached Related Party Schedule		

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	6 Repairs & maintenance	\$	Center for Residential Management, Inc.	**	\$ 184	\$	184	1
2	V	10 Medical supplies		Center for Residential Management, Inc.	**	289		289	2
3	V	11 Activity programming		Center for Residential Management, Inc.	**	1,142		1,142	3
4	V	17 Management fees	7,906	Center for Residential Management, Inc.	**	7,919		13	4
5	V	18 Board fees		Center for Residential Management, Inc.	**	755		755	5
6	V	19 Professional fees		Center for Residential Management, Inc.	**	1,344		1,344	6
7	V	20 Licenses, dues & subscriptions		Center for Residential Management, Inc.	**	138		138	7
8	V	21 Office supplies & telephone		Center for Residential Management, Inc.	**	4,096		4,096	8
9	V	22 Employee benefits & payroll taxes		Center for Residential Management, Inc.	**	9,948		9,948	9
10	V	23 Inservice travel & education		Center for Residential Management, Inc.	**				10
11	V	24 Travel & seminar		Center for Residential Management, Inc.	**	815		815	11
12	V	25 Vehicle expense		Center for Residential Management, Inc.	**	90		90	12
13	V	26 Vehicle, fire & liability insurance		Center for Residential Management, Inc.	**	57		57	13
14	Total		\$ 7,906			\$ 26,777	\$ *	18,871	14

\*\* Center for Residential Management, Inc. is

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

SEE ACCOUNTANTS' COMPILATION REPORT Residential Centers, Inc.'s parent company.

VII. RELATED PARTIES (continued)

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:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	30 Depreciation	\$	Center for Residential Management, Inc.	**	\$ 315	\$ 315	15	
16	V	32 Interest expense		Center for Residential Management, Inc.	**	205	205	16	
17	V							17	
18	V							18	
19	V							19	
20	V							20	
21	V							21	
22	V							22	
23	V							23	
24	V							24	
25	V							25	
26	V							26	
27	V							27	
28	V							28	
29	V							29	
30	V							30	
31	V							31	
32	V							32	
33	V							33	
34	V							34	
35	V							35	
36	V							36	
37	V							37	
38	V							38	
39	Total		\$			\$ 520	\$ *	520	39

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

SEE ACCOUNTANTS' COMPILATION REPORT \*\* Center for Residential Management, Inc. is Residential Centers, Inc.'s parent company.

Facility Name & ID Number Ellner Terrace

# 0036327

Report Period Beginning: 7/1/99

Ending: 6/30/00

VII. RELATED PARTIES (continued)

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:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 Management fees	\$	Residential Centers, Inc.	100.00%	\$ 16,720	\$ 16,720
16	V	18 Board fees		Residential Centers, Inc.	100.00%	2,009	2,009
17	V	19 Professional fees		Residential Centers, Inc.	100.00%	3,646	3,646
18	V	20 Licenses, dues & subscriptions		Residential Centers, Inc.	100.00%	11	11
19	V	21 Office supplies & telephone		Residential Centers, Inc.	100.00%	175	175
20	V	22 Employee benefits & payroll taxes		Residential Centers, Inc.	100.00%	5,424	5,424
21	V	24 Travel & seminar		Residential Centers, Inc.	100.00%	77	77
22	V	26 Vehicle, fire & liability insurance		Residential Centers, Inc.	100.00%	3,880	3,880
23	V	32 Interest expense		Residential Centers, Inc.	100.00%	2,921	2,921
24	V	42 Provider participation fees		Residential Centers, Inc.	100.00%	7,072	7,072
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 41,935	\$ * 41,935

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	5 Utilities	\$	Developmental Services of Illinois, Inc.	**	\$ 43	\$ 43
16	V	6 Repairs & maintenance		Developmental Services of Illinois, Inc.	**	543	543
17	V	11 Activity programming		Developmental Services of Illinois, Inc.	**	71	71
18	V	17 Management fees	52,718	Developmental Services of Illinois, Inc.	**		(52,718)
19	V	19 Professional fees		Developmental Services of Illinois, Inc.	**	5,228	5,228
20	V	20 Licenses, dues & subscriptions		Developmental Services of Illinois, Inc.	**	157	157
21	V	21 Office supplies & telephone		Developmental Services of Illinois, Inc.	**	4,600	4,600
22	V	22 Employee benefits & payroll taxes		Developmental Services of Illinois, Inc.	**	2,346	2,346
23	V	23 Inservice travel & education		Developmental Services of Illinois, Inc.	**	799	799
24	V	24 Travel & seminar		Developmental Services of Illinois, Inc.	**	1,087	1,087
25	V	25 Vehicle expense		Developmental Services of Illinois, Inc.	**	24	24
26	V	26 Vehicle, fire & liability insurance		Developmental Services of Illinois, Inc.	**	369	369
27	V	30 Depreciation		Developmental Services of Illinois, Inc.	**	426	426
28	V	32 Interest expense		Developmental Services of Illinois, Inc.	**	2,511	2,511
29	V	34 Rent		Developmental Services of Illinois, Inc.	**	1,386	1,386
30	V	35 Vehicle lease & equipment rental		Developmental Services of Illinois, Inc.	**	1,506	1,506
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 52,718			\$ 21,096	\$ * (31,622)

\*\* Developmental Services of Illinois, Inc. is Residential

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

SEE ACCOUNTANTS' COMPILATION REPORT Centers, Inc.'s management company.

Facility Name & ID Number Ellner Terrace

# 0036327

Report Period Beginning: 7/1/99

Ending: 6/30/00

VII. RELATED PARTIES (continued)

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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0 \$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0 \$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0 \$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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	
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 0	\$ *

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0 \$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ellner Terrace

# 0036327

Report Period Beginning: 7/1/99

Ending: 6/30/00

VII. RELATED PARTIES (continued)

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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0 \$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number      Ellner Terrace      #      0036327      Report Period Beginning:      7/1/99      Ending:      6/30/00

## 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	Ronald Schroeder	President	Board Member	None	13,522	2 hrs/mtg.		Directors Fees	\$ 278	L18, C8	1
2	Edward Childers	Secretary	Board Member	None	13,351	2 hrs/mtg.		Directors Fees	649	L18, C8	2
3	Robert Bauer	Treasurer	Board Member	None	11,538	2 hrs/mtg.		Directors Fees	462	L18, C8	3
4	Eugene Humphrey	Vice President	Board Member	None	7,705	2 hrs/mtg.		Directors Fees	295	L18, C8	4
5	Orland Bauer	Director	Board Member	None	8,687	2 hrs/mtg.		Directors Fees	113	L18, C8	5
6	Shawn Jeffers	Director	Board Member	None	2,843	2 hrs/mtg.		Directors Fees	357	L18, C8	6
7	Darrell Boehne	Director	Board Member	None	12,390	2 hrs/mtg.		Directors Fees	610	L18, C8	7
8											8
9											9
10											10
11											11
12	See Attached Schedule 7A										12
13								TOTAL	\$ 2,764		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 Ellner Terrace

# 0036327 Report Period Beginning: 7/1/99

Ending: 6/30/00

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 Center for Residential Management, Inc.  
 Street Address 4239 W. War Memorial Drive, Suite 302  
 City / State / Zip Code Peoria, IL 61614  
 Phone Number ( 309) 685-0595  
 Fax Number ( 309) 685-8463

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	Repairs & maintenance	Bed days available	206,424	20	\$ 6,488	\$ 5,856	\$ 184	1
2	10	Medical supplies	Bed days available	206,424	20	10,160	5,856	289	2
3	17	Management fees	Bed days available	206,424	20	279,150	5,856	7,919	3
4	18	Board fees	Bed days available	206,424	20	26,600	5,856	755	4
5	19	Professional fees	Bed days available	206,424	20	47,365	5,856	1,344	5
6	20	Licenses, dues & subscriptions	Bed days available	206,424	20	401	5,856	12	6
7	21	Office supplies & telephone	Bed days available	206,424	20	14,574	5,856	414	7
8	22	Employee benefits & payroll taxes	Bed days available	206,424	20	27,615	5,856	783	8
9	24	Travel & seminar	Bed days available	206,424	20	7,941	5,856	225	9
10	25	Vehicle expense	Bed days available	206,424	20	3,189	5,856	90	10
11	26	Vehicle, fire & liability insurance	Bed days available	206,424	20	2,009	5,856	57	11
12	30	Depreciation	Bed days available	206,424	20	11,103	5,856	315	12
13	32	Interest expense	Bed days available	206,424	20	7,240	5,856	205	13
14									14
15									15
16									16
17	11	Activity programming	Direct method					1,142	17
18	20	Licenses, dues & subscriptions	Direct method					126	18
19	21	Office supplies & telephone	Direct method					3,682	19
20	22	Employee benefits & payroll taxes	Direct method					9,165	20
21	24	Travel & seminar	Direct method					590	21
22									22
23									23
24									24
25	TOTALS					\$ 443,835	\$	\$ 27,297	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ellner Terrace

# 0036327 Report Period Beginning: 7/1/99

Ending: 6/30/00

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 Residential Centers, Inc.  
 Street Address 4239 W. War Memorial Drive, Suite 302  
 City / State / Zip Code Peoria, IL 61614  
 Phone Number (309) 685-0595  
 Fax Number (309) 685-8463

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	17	Management fees	Number of beds	193	4	\$ 96,535	\$ 16	\$ 16,720	1
2	18	Board fees	Number of beds	193	4	21,800	16	2,009	2
3	19	Professional fees	Number of beds	193	4	43,931	16	3,646	3
4	20	Licenses, dues & subscriptions	Number of beds	193	4	138	16	11	4
5	21	Office supplies & telephone	Number of beds	193	4	2,100	16	175	5
6	24	Travel & seminar	Number of beds	193	4	1,268	16	77	6
7	32	Interest expense	Number of beds	193	4	93,326	16	2,921	7
8	42	Provider participation fees	Number of beds	193	4	101,704	16	7,072	8
9									9
10									10
11	22	Employee benefits & payroll taxes	Direct method					5,424	11
12	26	Vehicle, fire & liability insurance	Direct method					3,880	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					\$ 360,802	\$	\$ 41,935	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ellner Terrace

# 0036327 Report Period Beginning: 7/1/99

Ending: 6/30/00

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 Developmental Services of Illinois, Inc.  
 Street Address 4239 W. War Memorial Drive, Suite 302  
 City / State / Zip Code Peoria, IL 61614  
 Phone Number (309) 685-0595  
 Fax Number (309) 685-8463

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	5	Utilities	Bed days available	206,424	20	\$ 1,518	\$ 5,856	\$ 43	1
2	6	Repairs & maintenance	Bed days available	206,424	20	19,133	5,856	543	2
3	11	Activity programming	Bed days available	206,424	20	2,500	5,856	71	3
4	19	Professional fees	Bed days available	206,424	20	184,323	5,856	5,228	4
5	20	Licenses, dues & subscriptions	Bed days available	206,424	20	5,518	5,856	157	5
6	21	Office supplies & telephone	Bed days available	206,424	20	162,176	5,856	4,600	6
7	22	Employee benefits & payroll taxes	Bed days available	206,424	20	82,697	5,856	2,346	7
8	23	Inservice travel & education	Bed days available	206,424	20	28,154	5,856	799	8
9	24	Travel & seminar	Bed days available	206,424	20	38,328	5,856	1,087	9
10	25	Vehicle expense	Bed days available	206,424	20	846	5,856	24	10
11	26	Vehicle, fire & liability insurance	Bed days available	206,424	20	13,012	5,856	369	11
12	30	Depreciation	Bed days available	206,424	20	15,000	5,856	426	12
13	32	Interest expense	Bed days available	206,424	20	88,507	5,856	2,511	13
14	34	Rent	Bed days available	206,424	20	48,842	5,856	1,386	14
15	35	Vehicle lease & equipment rental	Bed days available	206,424	20	53,081	5,856	1,506	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 743,635	\$	\$ 21,096	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ellner Terrace

# 0036327

Report Period Beginning:

7/1/99

Ending: 6/30/00

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

# 0036327 Report Period Beginning: 7/1/99

Ending: 6/30/00

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									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 Ellner Terrace # 0036327 Report Period Beginning: 7/1/99 Ending: 6/30/00

## 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
	<b>A. Directly Facility Related</b>																			
	<b>Long-Term</b>																			
1	NCS Healthcare, Inc.		x	Software/Hardware	\$145.00	10/31/98	\$ 5,783	\$ 3,640	09/30/03	0.1429	\$ 326	1								
2												2								
3												3								
4												4								
5												5								
	<b>Working Capital</b>																			
6												6								
7												7								
8												8								
9	TOTAL Facility Related				\$145.00		\$ 5,783	\$ 3,640			\$ 326	9								
	<b>B. Non-Facility Related*</b>																			
10							Miscellaneous interest expense				3,434	10								
11							Offset interest income				(118)	11								
12							Allocated from parent & management company				2,716	12								
13							Nonallowable interest expense				(700)	13								
14	TOTAL Non-Facility Related						\$	\$			\$ 5,332	14								
15	TOTALS (line 9+line14)						\$ 5,783	\$ 3,640			\$ 5,658	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.)

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number Ellner Terrace# 0036327 Report Period Beginning:7/1/99 Ending:6/30/00**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 4,100 B. General Construction Type: Exterior Wood with Siding Frame Wood Number of Stories OneC. 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: N/A 2. Number of Years Over Which it is Being Amortized: N/A  
3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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>N/A</u>			\$	1
2					2
3	<b>TOTALS</b>			\$	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ellner Terrace

# 0036327

Report Period Beginning:

7/1/99

Ending:

6/30/00

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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		Building Improvements	1994		6,426	428	15	428		2,784	9
10		Building Improvements	1995		1,301	87	15	87		478	10
11		Excavating	1996		1,100	73	15	73		280	11
12		Mixing Valve	1998		659	44	15	44		99	12
13		Tile	2000		542	16	15	16		16	13
14		Shower Faucet	2000		747	24	15	24		24	14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	<b>TOTAL (lines 4 thru 35)</b>				\$ 10,775	\$ 672		\$ 672	\$	\$ 3,681	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 ACCOUNTANTS' COMPILATION REPORT

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	
37	Purchased in Prior Years	\$ 21,504	\$ 2,295	\$ 2,295	\$	5-10 yrs	\$ 9,312	37
38	Current Year Purchases	3,842	224	224		10 yrs	224	38
39	Fully Depreciated Assets							39
40	Parent & management company allocation			741	741			40
41	TOTALS	\$ 25,346	\$ 2,519	\$ 3,260	\$ 741		\$ 9,536	41

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	
42				\$	\$	\$	\$		\$	42
43										43
44										44
45										45
46	TOTALS			\$	\$	\$	\$		\$	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 36,121	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 3,191	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 3,932	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 741	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 13,217	51

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ellner Terrace# 0036327Report Period Beginning: 7/1/99Ending: 6/30/00**XII. RENTAL COSTS****A. Building and Fixed Equipment (See instructions.)**1. Name of Party Holding Lease: Community Living Options

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:		16	06/01/00	\$ 63,926	5	10	3
4	Additions							4
5								5
6	Management company allocation				1,386			6
7	TOTAL		16		\$ 65,312			7

## 10. Effective dates of current rental agreement:

Beginning 06/01/00Ending 05/31/05

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

Fiscal Year Ending      Annual Rent

12. 06/30/2001      \$ 69,25513. 06/30/2002      \$ 69,25514. 06/30/2003      \$ 69,255

## 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 N/A.N/AN/A

## 9. Option to Buy:

YES

NO

Terms: N/A

\*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

 YES  NO16. Rental Amount for movable equipment: \$ 1,503Description: Management company allocation \$1,503

(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	Resident care	1992 Chevy Van	\$ 589.00	\$ 7,068	17
18	Resident care	1995 Chevy Corsica	381.00	4,572	18
19					19
20	Management company allocation			3	20
21	TOTAL		\$ 970.00	\$ 11,643	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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 checked="" type="checkbox"/> YES <input 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 checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE <u>40</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE <u>80</u></p>
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	1,620	\$	\$ 1,620
2	Books and Supplies		225		225
3	Classroom Wages (a)		6,610		6,610
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	8,455	\$	\$ 8,455
10	SUM OF line 9, col. 1 and 2 (e)	\$	8,455		

- (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	9
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	9

- (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	Emergency Dental Other (specify): <b>Eye Care</b>	L39, C3 L39, C3			50 6	1,116 353		50 6	1,116 353	13
14	<b>TOTAL</b>			\$	56	\$ 1,469	\$	56	\$ 1,469	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 &amp; ID Number Ellner Terrace

# 0036327

Report Period Beginning: 7/1/99

Ending:

6/30/00

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/00

(last day of reporting year)

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

	1	2	
	Operating	After Consolidation*	
<b>A. Current Assets</b>			
1 Cash on Hand and in Banks	\$	\$	1
2 Cash-Patient Deposits			2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance 1,622 )	51,581	51,581	3
4 Supply Inventory (priced at )			4
5 Short-Term Investments			5
6 Prepaid Insurance	687	687	6
7 Other Prepaid Expenses	9,897	9,897	7
8 Accounts Receivable (owners or related parties)	129,262	129,262	8
9 Other(specify): See Attached Schedule 17A	35,213	35,213	9
10 <b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 226,640	\$ 226,640	10
<b>B. Long-Term Assets</b>			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land			13
14 Buildings, at Historical Cost			14
15 Leasehold Improvements, at Historical Cost	10,775	10,775	15
16 Equipment, at Historical Cost	25,346	25,346	16
17 Accumulated Depreciation (book methods)	(13,217)	(13,217)	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):			23
24 <b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 22,904	\$ 22,904	24
25 <b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 249,544	\$ 249,544	25

	1	2	
	Operating	After Consolidation*	
<b>C. Current Liabilities</b>			
26 Accounts Payable	\$ 60,739	\$ 60,739	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits			28
29 Short-Term Notes Payable			29
30 Accrued Salaries Payable	8,870	8,870	30
31 Accrued Taxes Payable (excluding real estate taxes)			31
32 Accrued Real Estate Taxes(Sch.IX-B)			32
33 Accrued Interest Payable			33
34 Deferred Compensation			34
35 Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>			
36 See Attached Schedule 17A	21,700	21,700	36
37			37
38 <b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 91,309	\$ 91,309	38
<b>D. Long-Term Liabilities</b>			
39 Long-Term Notes Payable	3,640	3,640	39
40 Mortgage Payable			40
41 Bonds Payable			41
42 Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>			
43			43
44			44
45 <b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 3,640	\$ 3,640	45
46 <b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 94,949	\$ 94,949	46
47 <b>TOTAL EQUITY(page 18, line 24)</b>	\$ 154,595	\$ 154,595	47
48 <b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 249,544	\$ 249,544	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**Ellner Terrace  
Provider #0036327  
6/30/2000**

XV. Balance Sheet

<u>Line 9 - Other Current Assets</u>	<u>Operating</u>	<u>After Consolidation</u>
Prepaid Deposits	15,750	15,750
Due From Third Party	<u>19,463</u>	<u>19,463</u>
Total	<u><u>35,213</u></u>	<u><u>35,213</u></u>

Line 36 - Other Current Liabilities

Accrued Expenses	10,585	10,585
Accrued Legal & Accounting	3,822	3,822
Accrued Participation Fees	7,071	7,071
Accrued Insurance Payable	<u>222</u>	<u>222</u>
	<u><u>21,700</u></u>	<u><u>21,700</u></u>

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ 176,506	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ 176,506	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	34,730	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) <b>Parent company &amp; management allocation</b>	(56,641)	15
16	Other (describe) <b>(added back in column 7)</b>		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (21,911)	17
	<b>B. Transfers (Itemize):</b>		
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 154,595	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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 479,968	1
2	Discounts and Allowances for all Levels		2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 479,968</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
9	Payments for Education	149,201	9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	8,877	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 158,078</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	118	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 118</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 638,164</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	69,296	31
32	Health Care	118,661	32
33	General Administration	163,293	33
<b>B. Capital Expense</b>			
34	Ownership	79,596	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	151,373	35
36	Provider Participation Fee	21,215	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 603,434</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>34,730</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 34,730</b>	<b>43</b>

\* 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. A federal tax return is filed for the combined divisions of Residential Centers, Inc.

\*\*\* 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 Ellner Terrace

# 0036327

Report Period Beginning: 7/1/99

Ending:

6/30/00

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			\$	\$	1
2					2
3					3
4	62	62	930	15.00	4
5					5
6	1,080	1,080	6,610	6.12	6
7					7
8					8
9					9
10					10
11					11
12					12
13					13
14					14
15	2,188	2,320	13,882	5.98	15
16					16
17	997	1,210	11,500	9.50	17
18					18
19					19
20	1,831	1,983	22,911	11.55	20
21					21
22	260	269	6,229	23.16	22
23					23
24	721	740	19,524	26.38	24
25					25
26					26
27					27
28					28
29					29
30	14,082	15,133	93,724	6.19	30
31					31
32					32
33					33
34	21,221	22,797	\$ 175,310 *	\$ 7.69	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	Monthly	\$ 840	L1, C3	35
36	Monthly	1,200	L9, C3	36
37				37
38				38
39	Monthly	164	L10, C3	39
40	3	165	L10a, C3	40
41	5	251	L10a, C3	41
42				42
43	6	330	L10a, C3	43
44	9	1,142	L11, C8	44
45	39	1,855	L12, C3	45
46				46
47	Monthly	2,330	L10, C3	47
48				48
49	62	\$ 8,277		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50		\$		50
51		N/A		51
52				52
53		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT



Ellner Terrace  
Provider #0036327  
6/30/2000

Schedule 21C

XIX. Support Schedules  
Section C. Professional Services

<b>TOTAL (agree to Schedule V, line 19, column 3)</b>		48,484
Management Company Allocation		
American Express Tax & Business Services	Accounting	797
Altschuler, Melvoin & Glasser LLP	Accounting	1,512
ADP	Payroll Processing	2,589
Health Outcomes	Consulting	330
Parent Company Allocation		
American Express Tax & Business Services	Accounting	77
Altschuler, Melvoin & Glasser LLP	Accounting	466
Mangum, Smietanka & Johnson	Legal	801
Corporate Allocation		
American Express Tax & Business Services	Accounting	660
Altschuler, Melvoin & Glasser LLP	Accounting	1,755
Mangum, Smietanka & Johnson	Legal	1,231
<b>TOTAL (agree to Schedule V, line 19, column 8)</b>		<u><u>58,702</u></u>

SEE ACCOUNTANTS' COMPILATION REPORT

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

1	2	3	4	5										
				6										
1	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year									
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	
2			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	
3		N/A												
4														
5														
6														
7														
8														
9														
10														
11														
12														
13														
14														
15														
16														
17														
18														
19														
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	

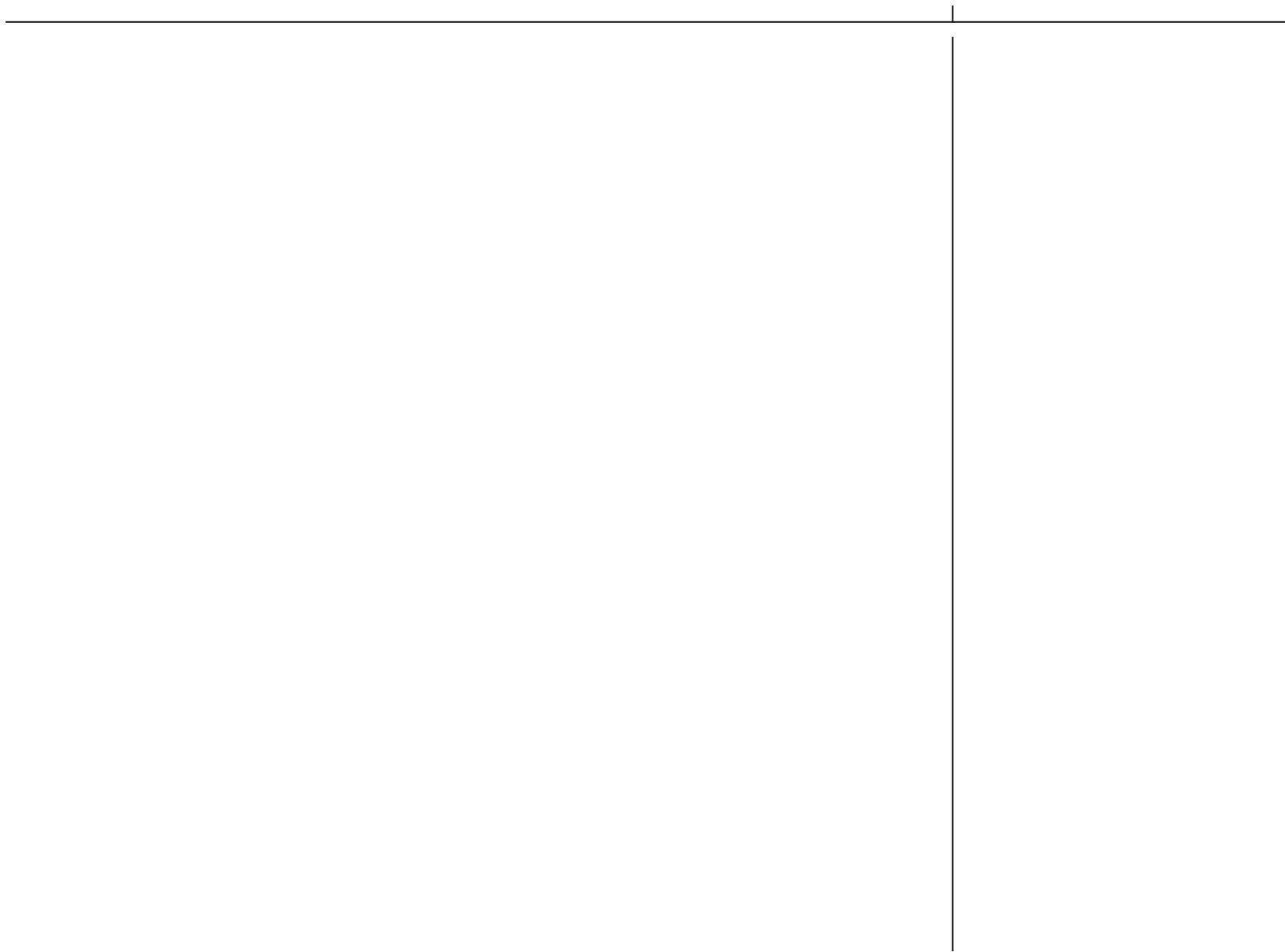
SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. Illinois Health Care Association \$826
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line n/a
- (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. \$ 28,287  
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.

SEE ACCOUNTANTS' COMPILATION REPORT

- (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. \$ 2,969 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
  - a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
  - b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
  - c. What percent of all travel expense relates to transportation of nurses and patients? 73%
  - d. Have vehicle usage logs been maintained? Adequate records are maintained
  - 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: Altschuler, Melvoin & Glasser 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 currently in progress
- (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? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.



==

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

==

===

—

===

===

==

—

—

—  
—

—

—  
—

—

—

—

—

—

—

—

—

—

—

—