

		FOR OHF USE				

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

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>0035253</u></p> <p>Facility Name: <u>South Haven Home</u></p> <p>Address: <u>500 S. Reed</u> <u>Robinson</u> <u>62454</u> Number City Zip Code</p> <p>County: <u>Crawford</u></p> <p>Telephone Number: <u>(618) 346-1204</u> Fax # <u>(217) 398-0944</u></p> <p>IDPA ID Number: <u>37-1225266003</u></p> <p>Date of Initial License for Current Owners: <u>01/25/89</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>Alan G. Ryle</u> Telephone Number: <u>(217) 398-6529</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>10/01/99</u> to <u>09/30/00</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 style="width: 20%;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) <u>Alan G. Ryle</u> (Title) <u>President</u></td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) <u>See Attached Compilation Report</u> (Print Name and Title) <u>David W. Hood, CPA - Partner</u> (Firm Name & Address) <u>Martin, Hood, Friese & Associates, LLC</u> <u>2507 S. Neil Street, Champaign, IL 61820</u> (Telephone) <u>(217) 351-2000</u> Fax # <u>(217) 351-7726</u></td> </tr> </table> <p align="right">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) _____ (Type or Print Name) <u>Alan G. Ryle</u> (Title) <u>President</u>	Paid Preparer	(Signed) <u>See Attached Compilation Report</u> (Print Name and Title) <u>David W. Hood, CPA - Partner</u> (Firm Name & Address) <u>Martin, Hood, Friese & Associates, LLC</u> <u>2507 S. Neil Street, Champaign, IL 61820</u> (Telephone) <u>(217) 351-2000</u> Fax # <u>(217) 351-7726</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Haven Home

0035253 Report Period Beginning: 10/01/99 Ending: 09/30/00

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 _____

	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	16	ICF/DD 16 or Less	16	5,856	6
7	16	TOTALS	16	5,856	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	Other		
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,261			5,261	13
14	TOTALS	5,261			5,261	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.84%

D. How many bed-hold days during this year were paid by Public Aid? 114 (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 01/11/89

J. Was the facility purchased or leased after January 1, 1978?
YES Date 01/11/89 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: 12/31/00 Fiscal Year: 09/30/00
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number

South Haven Home

0035253

Report Period Beginning:

10/01/99

Ending:

09/30/00

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
	A. General Services										
1	Dietary	26,786		1,885	28,671		28,671		28,671		1
2	Food Purchase		27,599		27,599		27,599	514	28,113		2
3	Housekeeping	16,425	5,273		21,698		21,698	241	21,939		3
4	Laundry	13,688			13,688		13,688		13,688		4
5	Heat and Other Utilities			11,316	11,316		11,316	618	11,934		5
6	Maintenance	133		32,398	32,531		32,531	(3,015)	29,516		6
7	Other (specify):*										7
8	TOTAL General Services	57,032	32,872	45,599	135,503		135,503	(1,642)	133,861		8
	B. Health Care and Programs										
9	Medical Director		2,074		2,074		2,074	513	2,587		9
10	Nursing and Medical Records	72,462		71,640	144,102		144,102	(12,000)	132,102		10
10a	Therapy										10a
11	Activities	2,738	865	45	3,648		3,648		3,648		11
12	Social Services		361	4,200	4,561		4,561	4,495	9,056		12
13	Nurse Aide Training	3,600			3,600		3,600		3,600		13
14	Program Transportation			6,346	6,346		6,346	(3,412)	2,934		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	78,800	3,300	82,231	164,331		164,331	(10,404)	153,927		16
	C. General Administration										
17	Administrative		220	51,554	51,774		51,774	(24,652)	27,122		17
18	Directors Fees							210	210		18
19	Professional Services			8,431	8,431		8,431	(4,510)	3,921		19
20	Dues, Fees, Subscriptions & Promotions			2,493	2,493		2,493	203	2,696		20
21	Clerical & General Office Expenses	16,770	2,847	15,567	35,184		35,184	645	35,829		21
22	Employee Benefits & Payroll Taxes			22,487	22,487		22,487	16,038	38,525		22
23	Inservice Training & Education			2,100	2,100		2,100	(1,096)	1,004		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			2,720	2,720		2,720	2,351	5,071		25
26	Insurance-Prop.Liab.Malpractice			3,956	3,956		3,956	568	4,524		26
27	Other (specify):*										27
28	TOTAL General Administration	16,770	3,067	109,308	129,145		129,145	(10,243)	118,902		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	152,602	39,239	237,138	428,979		428,979	(22,289)	406,690		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

South Haven Home

#0035253

Report Period Beginning:

10/01/99

Ending:

09/30/00

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	
	D. Ownership											
30	Depreciation			2,467	2,467		2,467	6,521	8,988			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,860	3,860	(3,057)	803	1,976	2,779			32
33	Real Estate Taxes			5,548	5,548		5,548	323	5,871			33
34	Rent-Facility & Grounds			45,900	45,900		45,900	215	46,115			34
35	Rent-Equipment & Vehicles			4,840	4,840		4,840	888	5,728			35
36	Other (specify):* IL Repl. Tax			(7)	(7)		(7)	7				36
37	TOTAL Ownership			62,608	62,608	(3,057)	59,551	9,930	69,481			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			30,027	30,027		30,027		30,027			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			30,027	30,027		30,027		30,027			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	152,602	39,239	329,773	521,614	(3,057)	518,557	(12,359)	506,198			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 South Haven Home

0035253

Report Period Beginning: 10/01/99

Ending: 09/30/00

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				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
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				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(314)	20-3		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				25
26	Income Taxes and Illinois Personal Property Replacement Tax		7	36-3	26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (307)		\$	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 Sch. VIII	(12,052)		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (12,052)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (12,359)		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

ID# 0035253
 Report Period Beginning: 10/01/99
 Ending: 09/30/00

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
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76			76
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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
See Schedule VII C.		See Attached Schedule		Health Services Consu	Savoy, IL	Consulting
				Cobblestone Rehab	Savoy, IL	Consulting
				Specialized Developme	Savoy, IL	Long Term Care
				Developmental Founda	Savoy, IL	Long Term Care
				MBD, LLC	Savoy, IL	Rental Real Estate
				P & L Rentals	Savoy, IL	Rental Real Estate

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	See Schedule VIII						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 South Haven Home # 0035253 Report Period Beginning: 10/01/99 Ending: 09/30/00

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	Alan Ryle	President	Administrative	0.50	All of the related party wages are allocations from HSC. See attached allocation spreadsheet and explanation. These individuals receive no compensation from homes other than HSC.			Administrative	\$ 3,747	17-7	1
2	Alan Ryle	President	Administrative	0.50				Directors Fees	105	18-7	2
3	Lynn Ryle	Vice President	Administrative	0.50				Administrative	2,899	17-7	3
4	Lynn Ryle	Vice President	Administrative	0.50				Directors Fees	105	18-7	4
5	Scott Ryle		Maintenance					Maintenance	119	6-7	5
6	Nathan Ryle		Maintenance					Maintenance	21	6-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 6,996		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 South Haven Home

0035253 Report Period Beginning: 10/01/99

Ending: 09/30/00

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 Office Management
 Street Address 8 Dunlap Court
 City / State / Zip Code Savoy, IL 61874
 Phone Number (217) 398-0754
 Fax Number (217) 398-0944

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	21	Clerical & General Office	Actual Paid to Health Services Consultants		\$	\$		\$ (8,280)	1
2									2
3	2	Food Purchases	Days	6,570	18	1,458	0	365	81
4	5	Utilities	Days	6,570	18	9,774	0	365	543
5	17	Administration	Days	6,570	18	12,492	0	365	694
6	21	Clerical & General Office	Days	6,570	18	35,388	0	365	1,966
7	30	Depreciation	Days	6,570	18	21,222	0	365	1,179
8	32	Interest	Days	6,570	18	17,316	0	365	962
9	33	Real Estate Tax	Days	6,570	18	5,814	0	365	323
10	35	Equipment	Days	6,570	18	10,962	0	365	609
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				\$ 114,426	\$		\$ (1,923)	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Haven Home

0035253 Report Period Beginning: 10/01/99

Ending: 09/30/00

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 Health Services Consultants
 Street Address 8 Dunlap Court
 City / State / Zip Code Savoy, IL 61874
 Phone Number (217) 398-0754
 Fax Number (217) 398-0944

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	10	Nursing	Reverse expenses for actual amounts paid or		\$	\$		(69,463)	1		
2	6	Maintenance	accrued to HSC for services provided in order					(9,036)	2		
3	12	Social	to allocate HSC's actual expenses.					(4,200)	3		
4	17	Administrative						(51,300)	4		
5	21	Clerical						(3,025)	5		
6	23	Inservice						(2,100)	6		
7	14	Program Transportation						(5,181)	7		
8	19	Professional Services						(5,412)	8		
9									9		
10	1	Dietary	Revenue	4,279,847	13	27,180	27,180	149,718		10	
11	2	Food Purchases	Revenue	4,279,847	13	12,383		149,718	433	11	
12	3	Housekeeping	Revenue	4,279,847	13	6,892		149,718	241	12	
13	5	Heat & Utilities	Revenue	4,279,847	13	2,146		149,718	75	13	
14	6	Maintenance	Revenue	4,279,847	13	110,028	83,744	149,718	6,021	14	
15	9	Medical Director	Revenue	4,279,847	13	14,672		149,718	513	15	
16	10	Nursing	Revenue	4,279,847	13	1,758,196	1,709,441	149,718	57,463	16	
17	11	Activities	Revenue	4,279,847	13			149,718		17	
18	12	Social	Revenue	4,279,847	13	248,544	244,560	149,718	8,695	18	
19	13	Nurse Training	Revenue	4,279,847	13			149,718		19	
20	17	Administrative	Revenue	4,279,847	13	670,612	670,612	149,718	25,954	20	
21	18	Director's Fees	Revenue	4,279,847	13	6,000		149,718	210	21	
22	19	Professional Fees	Revenue	4,279,847	13	25,795		149,718	902	22	
23	20	Adv. Dues & Subscriptions	Revenue	4,279,847	13	14,777		149,718	517	23	
24	21	Clerical	Revenue	4,279,847	13	285,404	175,423	149,718	9,984	24	
25	TOTALS				\$	3,182,629	\$	2,910,960	\$	(38,709)	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Haven Home

0035253 Report Period Beginning: 10/01/99

Ending: 09/30/00

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 Health Services Consultants
 Street Address 8 Dunlap Court
 City / State / Zip Code Savoy, IL 61874
 Phone Number (217) 398-0754
 Fax Number (217) 398-0944

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	22	P/R Taxes & Benefits	Revenue	4,279,847	13	\$ 460,666	\$ 149,718	\$ 16,038	1
2	23	Inservice	Revenue	4,279,847	13	28,697	149,718	1,004	2
3	14	Program Transportation	Revenue	4,279,847	13	50,563	149,718	1,769	3
4	25	Administrative Transportation	Revenue	4,279,847	13	67,240	149,718	2,351	4
5	26	Insurance	Revenue	4,279,847	13	16,248	149,718	568	5
6	30	Depreciation	Revenue	4,279,847	13	152,693	149,718	5,342	6
7	32	Interest	Revenue	4,279,847	13	28,990	149,718	1,014	7
8	34	Building Lease	Revenue	4,279,847	13	6,150	149,718	215	8
9	35	Equipment Lease	Revenue	4,279,847	13	7,968	149,718	279	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					\$ 4,001,844	\$	\$ (10,129)	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	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	Schedule VIII Allocation		X									1,976	2						
3	Interest Income		X									(3,057)	3						
4													4						
5													5						
	Working Capital																		
6	Busey Bank		X	Revolving Line of Credit	N/A	N/A	N/A		N/A	9.5000		2,684	6						
7	Related Party	X		Working Capital	N/A	N/A	N/A		N/A	9.5000		1,176	7						
8													8						
9	TOTAL Facility Related						\$	\$			\$	2,779	9						
	B. Non-Facility Related*																		
10													10						
11													11						
12													12						
13													13						
14	TOTAL Non-Facility Related						\$	\$			\$		14						
15	TOTALS (line 9+line14)						\$	\$			\$	2,779	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.)

Facility Name & ID Number South Haven Home

0035253 Report Period Beginning:

10/01/99 Ending:

09/30/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,800 B. General Construction Type: Exterior Aluminum Siding Frame Wood Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Haven Home

0035253

Report Period Beginning:

10/01/99 Ending:

09/30/00

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
		Improvement Type**									
9		Leasehold Improvements	1994		1,721	76	39	76		307	9
10		Leasehold Improvements	1995		8,178	266	39	266		1,590	10
11		Leasehold Improvements - Furniture	1998		1,214	44	27.5	44		119	11
12		Leasehold Improvements - Bathroom Repairs	1999		966	35	27.5	35		45	12
13		Leasehold Improvements - Protective Wall Covering	2000		560	1	27.5	1		1	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		TOTAL (lines 4 thru 35)			\$ 12,639	\$ 422		\$ 422	\$	\$ 2,062	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

Facility Name & ID Number South Haven Home

0035253

Report Period Beginning:

10/01/99

Ending:

09/30/00

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	\$ 12,760	\$ 1,943	\$ 1,943	\$	5/7	\$ 5,396	37
38	Current Year Purchases							38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	\$ 12,760	\$ 1,943	\$ 1,943	\$		\$ 5,396	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	Patient Transportation	Passenger Van	1995	\$ 26,188	\$	\$	\$	5	\$ 26,188	42
43	Patient Transportation	Handicapped Conversion	1999	510	102	102		5	132	43
44										44
45										45
46	TOTALS			\$ 26,698	\$ 102	\$ 102	\$		\$ 26,320	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)	\$ 52,097	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 2,467	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 2,467	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 33,778	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.

SEE ACCOUNTANTS' COMPILATION REPORT

** 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: Milestone Midwest, Inc.

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>1988</u>	<u>15</u>	<u>1/11/89</u>	\$ <u>45,900</u>	<u>15</u>	<u>15</u>	3
4	Additions	<u>1991</u>	<u>1</u>					4
5								5
6								6
7	TOTAL		16		\$ 45,900			7

10. Effective dates of current rental agreement:

Beginning 1/11/89
Ending 1/10/04

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

	Fiscal Year Ending	Annual Rent
12.	<u>09/30/01</u>	\$ <u>45,900</u>
13.	<u>09/30/02</u>	\$ <u>45,900</u>
14.	<u>09/30/03</u>	\$ <u>45,900</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 None
N/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 NO

16. Rental Amount for movable equipment: \$ 4,840 Description: Fax & Copier Lease

(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 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	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)		1,200		1,200
4	Clinical Wages (b)		2,400		2,400
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$ 3,600	\$	\$ 3,600
10	SUM OF line 9, col. 1 and 2 (e)	\$	3,600		

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

C. CONTRACTUAL INCOME

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

\$ None

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	4
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	4

- (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	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost	Units	Cost				
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist		hrs	\$		\$		\$					\$	1
2	Licensed Speech and Language Development Therapist		hrs											2
3	Licensed Recreational Therapist		hrs											3
4	Licensed Physical Therapist		hrs											4
5	Physician Care		visits											5
6	Dental Care		visits											6
7	Work Related Program		hrs											7
8	Habilitation		hrs											8
9	Pharmacy		# of prescrpts											9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs											10
11	Academic Education		hrs											11
12	Exceptional Care Program													12
13	Other (specify):													13
14	TOTAL			\$		\$		\$		\$			\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Haven Home

0035253

Report Period Beginning: 10/01/99

Ending:

09/30/00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 09/30/00

(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	\$	1
2	Cash-Patient Deposits		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	101,777	3
4	Supply Inventory (priced at)		4
5	Short-Term Investments		5
6	Prepaid Insurance	7,855	6
7	Other Prepaid Expenses		7
8	Accounts Receivable (owners or related parties)		8
9	Other(specify):		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 109,632	10
B. Long-Term Assets			
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	12,639	15
16	Equipment, at Historical Cost	39,458	16
17	Accumulated Depreciation (book methods)	(33,778)	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	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 18,319	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 127,951	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26	Accounts Payable	\$	26
27	Officer's Accounts Payable		27
28	Accounts Payable-Patient Deposits		28
29	Short-Term Notes Payable		29
30	Accrued Salaries Payable	7,293	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,030	31
32	Accrued Real Estate Taxes(Sch.IX-B)	4,016	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)	\$ 12,339	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)	\$ 12,339	46
47	TOTAL EQUITY(page 18, line 24)	\$ 115,612	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 127,951	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 152,869	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 152,869	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(11,378)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (11,378)	17
B. Transfers (Itemize):			
18	Transfers to the Residential Developers, Inc.	(25,879)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (25,879)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 115,612	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Haven Home

0035253

Report Period Beginning: 10/01/99

Ending: 09/30/00

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	\$ 507,179	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 507,179	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***	3,057	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,057	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)	\$ 510,236	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	135,503	31
32	Health Care	164,331	32
33	General Administration	129,145	33
B. Capital Expense			
34	Ownership	62,608	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	30,027	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 521,614	40
41	Income before Income Taxes (line 30 minus line 40)**	(11,378)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (11,378)	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. Tax return is on a 12/31 fiscal year and is on the cash basis.

*** 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 **South Haven Home**

0035253

Report Period Beginning: **10/01/99**

Ending:

09/30/00

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					4
5					5
6	480	480	3,600	7.50	6
7					7
8					8
9					9
10	365	365	2,738	7.50	10
11					11
12					12
13					13
14	1,933	2,089	21,311	10.20	14
15	730	730	5,475	7.50	15
16					16
17	19	19	133	7.00	17
18	2,190	2,190	16,425	7.50	18
19	1,825	1,825	13,688	7.50	19
20					20
21					21
22					22
23					23
24	1,968	2,002	16,770	8.38	24
25					25
26					26
27					27
28					28
29					29
30	9,233	9,668	72,462	7.50	30
31					31
32					32
33					33
34	18,743	19,368	\$ 152,602 *	\$ 7.88	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	47	\$ 1,885	1-3	35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47	20	1,185	10-3	47
48	39	2,340	10-3	48
49	106	\$ 5,410		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

1	2	3	4	5										
				6										
1	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year									
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	
2			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	
3														
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. IHCA \$917.37
- (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? None
What was the average life used for new equipment added during this period? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ None 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.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 30,027
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes If YES, attach an explanation of the allocation.
- (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? None
- (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. \$ 5,175 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? Attached
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? None
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. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? None
- (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