

		FOR OHF USE				

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

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

<p><b>I. IDPH Facility ID Number:</b> <u>0035253</u></p> <p><b>Facility Name:</b> <u>South Haven Home</u></p> <p><b>Address:</b> <u>500 S. Reed</u> <u>Robinson</u> <u>62454</u> Number City Zip Code</p> <p><b>County:</b> <u>Crawford</u></p> <p><b>Telephone Number:</b> <u>(618) 346-1204</u> Fax # <u>(217) 398-0944</u></p> <p><b>IDPA ID Number:</b> <u>37-1225266003</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>01/25/89</u></p> <p><b>Type of Ownership:</b></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><b>In the event there are further questions about this report, please contact:</b> Name: <u>Dennis Carpenter</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><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>10/1/00</u> to <u>9/30/01</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td data-bbox="1144 678 1281 828">Officer or Administrator of Provider</td> <td data-bbox="1281 678 1921 747">(Signed) _____ (Date) _____ (Type or Print Name) <u>Dennis Carpenter</u></td> </tr> <tr> <td data-bbox="1144 828 1281 885"></td> <td data-bbox="1281 828 1921 885">(Title) <u>Chief Financial Officer</u></td> </tr> <tr> <td data-bbox="1144 885 1281 1039">Paid Preparer</td> <td data-bbox="1281 885 1921 1039">(Signed) <u>See Attached Compilation Report</u> (Date) _____ (Print Name and Title) <u>David W. Hood</u> <u>Member</u> (Firm Name &amp; Address) <u>Martin, Hood, Friese &amp; 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) _____ (Date) _____ (Type or Print Name) <u>Dennis Carpenter</u>		(Title) <u>Chief Financial Officer</u>	Paid Preparer	(Signed) <u>See Attached Compilation Report</u> (Date) _____ (Print Name and Title) <u>David W. Hood</u> <u>Member</u> (Firm Name & Address) <u>Martin, Hood, Friese &amp; 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: 10/1/00 Ending: 9/30/01

**III. STATISTICAL DATA**

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds \_\_\_\_\_

	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>5,840</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,840</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	Other		
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	<u>4,091</u>			<u>4,091</u>	13
14	TOTALS	<u>4,091</u>			<u>4,091</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.05%

D. How many bed-hold days during this year were paid by Public Aid?

94 (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 1/11/89

J. Was the facility purchased or leased after January 1, 1978?

YES  Date 1/11/89 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: 12/31/01 Fiscal Year: 9/30/01

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

Facility Name &amp; ID Number

South Haven Home

# 0035253

Report Period Beginning:

10/1/00

Ending:

9/30/01

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	29,353		1,568	30,921		30,921	1,415	32,336		1
2	Food Purchase		26,036		26,036		26,036	315	26,351		2
3	Housekeeping	18,133	2,776		20,909		20,909	15	20,924		3
4	Laundry	15,111			15,111		15,111		15,111		4
5	Heat and Other Utilities			12,436	12,436		12,436	790	13,226		5
6	Maintenance	307		30,108	30,415		30,415	(2,887)	27,528		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	62,904	28,812	44,112	135,828		135,828	(352)	135,476		8
	<b>B. Health Care and Programs</b>										
9	Medical Director		2,654	3,450	6,104		6,104	774	6,878		9
10	Nursing and Medical Records	62,604		72,394	134,998		134,998	(15,824)	119,174		10
10a	Therapy										10a
11	Activities	3,022	1,270	19	4,311		4,311	433	4,744		11
12	Social Services			4,200	4,200		4,200	(3,389)	811		12
13	Nurse Aide Training	5,796			5,796		5,796		5,796		13
14	Program Transportation			3,870	3,870		3,870	(3,797)	74		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	71,422	3,924	83,933	159,279		159,279	(21,802)	137,477		16
	<b>C. General Administration</b>										
17	Administrative			52,956	52,956		52,956	(15,313)	37,643		17
18	Directors Fees							178	178		18
19	Professional Services			9,919	9,919		9,919	(3,345)	6,575		19
20	Dues, Fees, Subscriptions & Promotions			2,189	2,189		2,189	97	2,286		20
21	Clerical & General Office Expenses	12,089	3,321	13,628	29,038		29,038	3,174	32,212		21
22	Employee Benefits & Payroll Taxes			17,920	17,920		17,920	24,759	42,679		22
23	Inservice Training & Education			2,512	2,512		2,512	(405)	2,107		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			1,658	1,658		1,658	5,003	6,661		25
26	Insurance-Prop.Liab.Malpractice			3,278	3,278		3,278	1,166	4,444		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	12,089	3,321	104,060	119,470		119,470	15,315	134,785		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	146,415	36,057	232,105	414,577		414,577	(6,839)	407,738		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 &amp; ID Number

South Haven Home

#0035253

Report Period Beginning:

10/1/00

Ending:

9/30/01

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			2,403	2,403		2,403	5,463	7,866			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,271	2,271		2,271	(285)	1,986			32
33	Real Estate Taxes			2,089	2,089		2,089	307	2,396			33
34	Rent-Facility & Grounds			45,900	45,900		45,900	1,413	47,313			34
35	Rent-Equipment & Vehicles			3,804	3,804		3,804	741	4,545			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			56,467	56,467		56,467	7,639	64,106			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
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			29,150	29,150		29,150		29,150			42
43	Other (specify):* <b>IL Repl. Tax</b>			1,013	1,013		1,013	(1,013)				43
44	<b>TOTAL Special Cost Centers</b>			30,163	30,163		30,163	(1,013)	29,150			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	146,415	36,057	318,735	501,207		501,207	(213)	500,994			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: 10/1/00

Ending: 9/30/01

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				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	(2,223)	32-3		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	(207)	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	(1,013)	43-3		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (3,443)</b>		<b>\$</b>	<b>30</b>

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	3,230		35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ 3,230</b>		<b>36</b>
37	<b>TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)</b>	<b>\$ (213)</b>		<b>37</b>

\*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	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

SEE ACCOUNTANTS' COMPILATION REPORT

South Haven Home

ID# 0035253

Report Period Beginning: 10/1/00

Ending: 9/30/01

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
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31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	<b>Total</b>	0	49





Facility Name & ID Number South Haven Home

# 0035253

Report Period Beginning:

10/1/00

Ending:

9/30/01

**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Schedule VII C.		See Attached Schedule		Health Services Cons.,	Champaign, IL	Consulting
				Cobblestone Rehabilit	Champaign, IL	Therapy
				Specialized Developme	Champaign, IL	Long Term Care
				Developmental Found	Champaign, IL	Long Term Care
				MBD, LLC	Champaign, IL	Rental Real Estate
				P&L Rentals	Champaign, 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:	
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)	
1	V	See Schedule VIII	\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number      South Haven Home      #      0035253      Report Period Beginning:      10/1/00      Ending:      9/30/01

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Alan Ryle	President	Administrative	0.50	All related party wages are allocations			Administrative	\$ 3,194	17-7	1
2	Alan Ryle	President	Administrative	0.50	from HSC. See attached allocation			Directors Fees	89	18-7	2
3	Lynn Ryle	Vice President	Administrative	0.50	spreadsheet and explanation. These			Administrative	2,471	17-7	3
4	Lynn Ryle	Vice President	Administrative	0.50	individuals receive no compensation from			Directors Fees	89	18-7	4
5	Nathan Ryle		Maintenance		entities other than HSC.			Maintenance	233	6-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 6,076		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: 10/1/00 Ending: 9/30/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

Name of Related Organization Office Management - division of TRD, Inc.  
 Street Address P.O. Box 1044  
 City / State / Zip Code Champaign, IL 61824  
 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	21	Clerical & General Office	Actual Paid to Office Management		\$	\$		\$ (4,658)	1	
2									2	
3	2	Food Purchases	Days	6,935	19	1,684	0	365	89	
4	5	Utilities	Days	6,935	19	7,130	0	365	375	
5	17	Administration	Days	6,935	19	7,052	0	365	371	
6	21	Clerical & General Office	Days	6,935	19	19,282	0	365	1,015	
7	30	Depreciation	Days	6,935	19	19,730	0	365	1,038	
8	32	Interest	Days	6,935	19	15,388	0	365	810	
9	33	Real Estate Tax	Days	6,935	19	5,826	0	365	307	
10	35	Equipment	Days	6,935	19	7,848	0	365	413	
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				\$	83,940	\$		\$ (240)	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Haven Home# 0035253 Report Period Beginning: 10/1/00Ending: 9/30/01

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

Name of Related Organization Health Services Consultants, Inc.  
 Street Address P.O. Box 1044  
 City / State / Zip Code Champaign, IL 61824  
 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			\$	\$		(77,346)	1		
2	6	Maintenance						(9,667)	2		
3	12	Social						(4,550)	3		
4	17	Administrative						(57,320)	4		
5	21	Clerical						(5,216)	5		
6	23	Inservice						(2,200)	6		
7	14	Program Transportation						(3,797)	7		
8	19	Professional Services						(6,280)	8		
9	1	Dietary						(847)	9		
10									10		
11	1	Dietary	Revenue	5,631,175	13	28,842	28,842	167,221	2,262	11	
12	2	Food Purchases	Revenue	5,631,175	13	7,612		167,221	226	12	
13	3	Housekeeping	Revenue	5,631,175	13	499		167,221	15	13	
14	5	Heat & Utilities	Revenue	5,631,175	13	13,965		167,221	415	14	
15	6	Maintenance	Revenue	5,631,175	13	125,380	115,524	167,221	6,780	15	
16	9	Medical Director	Revenue	5,631,175	13	26,052		167,221	774	16	
17	10	Nursing	Revenue	5,631,175	13	1,985,273	1,945,797	167,221	61,522	17	
18	11	Activities	Revenue	5,631,175	13	14,586		167,221	433	18	
19	12	Social	Revenue	5,631,175	13	258,295	246,415	167,221	1,161	19	
20	13	Nurse Training	Revenue	5,631,175	13			167,221		20	
21	17	Administrative	Revenue	5,631,175	13	966,392	966,392	167,221	41,636	21	
22	18	Director's Fees	Revenue	5,631,175	13	6,000		167,221	178	22	
23	19	Professional Services	Revenue	5,631,175	13	98,831		167,221	2,935	23	
24	20	Adv. Dues & Subscriptions	Revenue	5,631,175	13	10,225		167,221	304	24	
25	TOTALS				\$	3,541,952	\$	3,302,970	\$	(48,580)	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Haven Home

# 0035253 Report Period Beginning: 10/1/00

Ending: 9/30/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

Name of Related Organization Health Services Consultants, Inc.  
 Street Address P.O. Box 1044  
 City / State / Zip Code Champaign, IL 61824  
 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					\$	\$			1	
2	21	Clerical	Revenue	5,631,175	13	405,207	279,728	167,221	12,033	2
3	22	P/R Taxes & Benefits	Revenue	5,631,175	13	740,124		167,221	24,759	3
4	23	Inservice	Revenue	5,631,175	13	60,461		167,221	1,795	4
5	14	Program Transportation	Revenue	5,631,175	13			167,221		5
6	25	Administrative Transportation	Revenue	5,631,175	13	168,501		167,221	5,003	6
7	26	Insurance	Revenue	5,631,175	13	39,280		167,221	1,166	7
8	30	Depreciation	Revenue	5,631,175	13	148,998		167,221	4,425	8
9	32	Interest	Revenue	5,631,175	13	37,992		167,221	1,128	9
10	34	Building Lease	Revenue	5,631,175	13	47,583		167,221	1,413	10
11	35	Equipment Lease	Revenue	5,631,175	13	11,034		167,221	328	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					\$ 5,201,132	\$ 3,582,698		\$ 3,470	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
	<b>A. Directly Facility Related</b>																			
	<b>Long-Term</b>																			
1	Schedule VIII Allocation		X				\$	\$			\$ 1,938	1								
2	Interest Income		X								(2,223)	2								
3												3								
4												4								
5												5								
	<b>Working Capital</b>																			
6	Busey Bank		X	Working Capital	N/A	N/A	N/A		N/A	6.0000	2,271	6								
7												7								
8												8								
9	TOTAL Facility Related						\$	\$			\$ 1,986	9								
	<b>B. Non-Facility Related*</b>																			
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$	\$			\$ 1,986	15								

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

(See instructions.)

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

(See instructions.)



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

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

**Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2000 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME South Haven Home COUNTY Crawford

FACILITY IDPH LICENSE NUMBER 0035253

CONTACT PERSON REGARDING THIS REPORT Dennis Carpenter

TELEPHONE (217) 398-6529 FAX #: (217) 398-0754

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>05-4-33-044-046-001</u>	<u>Facility</u>	\$ <u>5,486.00</u>	\$ <u>5,486.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>5,486.00</u>	\$ <u>5,486.00</u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number South Haven Home# 0035253 Report Period Beginning:10/1/00 Ending:9/30/01

## X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,800 B. General Construction Type: Exterior Aluminum Siding Frame Wood Number of Stories 1C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

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

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

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

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

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

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_

3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs:

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

## XI. OWNERSHIP COSTS:

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:

10/1/00

Ending:

9/30/01

**XI. OWNERSHIP COSTS (continued)**

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
		<b>Improvement Type**</b>									
9		Leasehold Improvements	1994		1,721	44	39	44		351	9
10		Leasehold Improvements	1995		8,178	210	39	210		1,800	10
11		Furniture	1998		1,214	45	27	45		164	11
12		Bathroom Repairs	1999		966	36	27	36		81	12
13		Protective Wall Covering	2000		560	21	27	21		22	13
14		Protective Wall Covering	2000		1,230	43	27	43		43	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

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

**XI. OWNERSHIP COSTS (continued)**

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

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 13,869	\$ 398		\$ 398	\$	\$ 2,460	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 10,961	\$ 1,903	\$ 1,903		5/7	\$ 5,500	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	1,799					1,799	73
74								74
75	TOTALS	\$ 12,760	\$ 1,903	\$ 1,903	\$		\$ 7,299	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	Passenger Van	1995	\$ 26,188	\$	\$		5	\$ 26,188	76
77	Patient Transportation	Handicapped Version	1999	510	102	102		5	234	77
78										78
79										79
80	TOTALS			\$ 26,698	\$ 102	\$ 102	\$		\$ 26,422	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 53,327	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 2,403	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 2,403	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 36,181	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: 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	<b>TOTAL</b>		<b>16</b>		\$ <b>45,900</b>			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>9/30/2002</u>	\$ <u>45,900</u>
13.	<u>9/30/2003</u>	\$ <u>45,900</u>
14.	<u>9/30/2004</u>	\$ <u>1,258</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: \$ 3,804 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	<b>TOTAL</b>		\$	\$	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)	276	1,656		1,932
4	Clinical Wages (b)	552	3,312		3,864
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$ 828	\$ 4,968	\$	\$ 5,796
10	SUM OF line 9, col. 1 and 2 (e)	\$ 5,796			

- (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	5
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	5
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>10</b>

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

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

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

## STATE OF ILLINOIS

Page 17

Facility Name &amp; ID Number South Haven Home

# 0035253

Report Period Beginning: 10/1/00

Ending:

9/30/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/01

(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 )	109,034		3
4 Supply Inventory (priced at )			4
5 Short-Term Investments			5
6 Prepaid Insurance			6
7 Other Prepaid Expenses	3,825		7
8 Accounts Receivable (owners or related parties)			8
9 Other(specify):			9
<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 112,859	\$	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	13,869		15
16 Equipment, at Historical Cost	39,458		16
17 Accumulated Depreciation (book methods)	36,181		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
<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 89,508	\$	24
<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 202,367	\$	25

	1	2	
	Operating	After Consolidation*	
<b>C. Current Liabilities</b>			
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	9,966		30
31 Accrued Taxes Payable (excluding real estate taxes)			31
32 Accrued Real Estate Taxes(Sch.IX-B)	4,321		32
33 Accrued Interest Payable			33
34 Deferred Compensation			34
35 Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>			
36			36
37			37
<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 14,287	\$	38
<b>D. Long-Term Liabilities</b>			
39 Long-Term Notes Payable			39
40 Mortgage Payable			40
41 Bonds Payable			41
42 Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>			
43			43
44			44
<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 14,287	\$	46
47 <b>TOTAL EQUITY</b> (page 18, line 24)	\$ 188,080	\$	47
<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 202,367	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 115,612	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 115,612	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(20,924)	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)	\$ (20,924)	17
<b>B. Transfers (Itemize):</b>			
18	Transfers (to) from The Residential Developers, Inc.	93,392	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 93,392	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 188,080	24 *

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

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Facility Name & ID Number South Haven Home

# 0035253

Report Period Beginning: 10/1/00

Ending: 9/30/01

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

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 478,060	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 478,060	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	2,223	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 2,223	26
<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>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 480,283	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	135,828	31
32	Health Care	159,279	32
33	General Administration	119,470	33
<b>B. Capital Expense</b>			
34	Ownership	56,467	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	29,150	36
<b>D. Other Expenses (specify):</b>			
37	Illinois Replacment Tax	1,013	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 501,207	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(20,924)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (20,924)	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: **10/1/00**Ending: **9/30/01**

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1			\$	\$	1
2					2
3					3
4					4
5					5
6	700	700	5,796	8.28	6
7					7
8					8
9					9
10	365	365	3,022	8.28	10
11					11
12					12
13					13
14	1,983	2,114	23,309	11.03	14
15	730	730	6,044	8.28	15
16					16
17	35	35	307	8.77	17
18	2,190	2,190	18,133	8.28	18
19	1,825	1,825	15,111	8.28	19
20					20
21					21
22					22
23					23
24	1,460	1,460	12,089	8.28	24
25					25
26					26
27					27
28					28
29					29
30	7,105	7,562	62,604	8.28	30
31					31
32					32
33					33
34	16,393	16,981	\$ 146,415 *	\$ 8.62	34

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

\*\* See instructions.

## B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	41	\$ 1,568	1-3	35
36	138	3,450	9-3	36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47	40	1,900	10-3	47
48	37	1,861	10-3	48
49	256	\$ 8,779		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

Facility Name & ID Number South Haven Home

# 0035253

Report Period Beginning: 10/1/00

Ending: 9/30/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
None			\$	Workers' Compensation Insurance	\$ 2,699	IDPH License Fee	\$ 400	
				Unemployment Compensation Insurance	1,826	Advertising: Employee Recruitment		
				FICA Taxes	11,201	Health Care Worker Background Check		
				Employee Health Insurance	(2,979)	(Indicate # of checks performed <u>6</u> )	72	
				Employee Meals	4,882	Dues & Subscriptions	1,510	
				Illinois Municipal Retirement Fund (IMRF)*		Contributions	207	
				Other	291	Schedule VIII Allocation	304	
				Schedule VIII Allocation	24,759			
TOTAL (agree to Schedule V, line 17, col. 1)			\$			Less: Contributions	(207)	
(List each licensed administrator separately.)						Less: Public Relations Expense	( )	
						Non-allowable advertising	( )	
						Yellow page advertising	( )	
						TOTAL (agree to Sch. V,	\$ 2,286	
						line 20, col. 8)		
B. Administrative - Other				TOTAL (agree to Schedule V,			\$ 42,679	
				line 22, col.8)				
Description			Amount					
Consulting			\$ 52,956					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 52,956	E. Schedule of Non-Cash Compensation Paid			G. Schedule of Travel and Seminar**	
(Attach a copy of any management service agreement)				to Owners or Employees				
C. Professional Services				Description			Description	
Vendor/Payee	Type	Amount		Line #	Amount		Amount	
Martin, Hood, Friese & Assoc.	Accounting	3,991		None		Out-of-State Travel	\$	
Dodd & McClellan	Legal	45						
Health Services Consultants	Accounting	3,666				In-State Travel		
Health Services Consultants	Computer Consulting	2,217						
						Seminar Expense		
						Entertainment Expense	( )	
						(agree to Sch. V,		
						line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			TOTAL	\$
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 9,919					

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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 - \$807
- (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? No
- (5) Have you properly capitalized all major repairs and equipment purchases? N/A  
What was the average life used for new equipment added during this period? no additions
- (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. \$ 29,150  
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. \$ 4,882 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