

Facility Name & ID Number Milestone-Searles

0027326 Report Period Beginning: 07/01/03 Ending: 06/30/04

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>12</u>	ICF/DD 16 or Less	<u>12</u>	<u>4,392</u>	6
7	<u>12</u>	TOTALS	<u>12</u>	<u>4,392</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	<u>4,357</u>			<u>4,357</u>	13
14	TOTALS	<u>4,357</u>			<u>4,357</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 99.20%

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

35 (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)

n/a

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 11/18/82

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

YES Date 02/11/82 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

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 06/30/04 Fiscal Year: 06/30/04

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

Facility Name & ID Number Milestone-Searles # 0027326 Report Period Beginning: 07/01/03 Ending: 06/30/04

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	17,859	1,856	435	20,150		20,150	20,150			1
2	Food Purchase		36,615		36,615		36,615	36,615			2
3	Housekeeping	13,900	5,652	784	20,336		20,336	20,336			3
4	Laundry										4
5	Heat and Other Utilities			11,542	11,542		11,542	11,542			5
6	Maintenance	13,454	18,531	4,246	36,231		36,231	36,231			6
7	Other (specify):* Maint. Fee			10,400	10,400		10,400	(10,400)			7
8	TOTAL General Services	45,213	62,654	27,407	135,274		135,274	(10,400)	124,874		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	260,224	589	1,752	262,565		262,565	262,565			10
10a	Therapy										10a
11	Activities		935		935		935	935			11
12	Social Services	10,757			10,757		10,757	10,757			12
13	Nurse Aide Training										13
14	Program Transportation		3,252	5,046	8,298		8,298	8,298			14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	270,981	4,776	6,798	282,555		282,555	282,555			16
	C. General Administration										
17	Administrative			11,811	11,811	(4,890)	6,921	6,921			17
18	Directors Fees										18
19	Professional Services			2,489	2,489		2,489	2,489			19
20	Dues, Fees, Subscriptions & Promotions			1,000	1,000		1,000	1,000			20
21	Clerical & General Office Expenses	10,855	5,177	3,932	19,964	4,890	24,854	24,854			21
22	Employee Benefits & Payroll Taxes			57,443	57,443		57,443	57,443			22
23	Inservice Training & Education										23
24	Travel and Seminar			1,358	1,358		1,358	1,358			24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			5,309	5,309		5,309	5,309			26
27	Other (specify):* Management Fee			4,320	4,320		4,320	(4,320)			27
28	TOTAL General Administration	10,855	5,177	87,662	103,694		103,694	(4,320)	99,374		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	327,049	72,607	121,867	521,523		521,523	(14,720)	506,803		29

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

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

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			12,113	12,113	879	12,992		12,992			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			24,163	24,163		24,163	(267)	23,896			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			23,940	23,940		23,940	(23,940)				34
35	Rent-Equipment & Vehicles			599	599	(599)						35
36	Other (specify):* Alloc.Maint. Bldg			280	280	(280)						36
37	TOTAL Ownership			61,095	61,095		61,095	(24,207)	36,888			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			29,895	29,895		29,895		29,895			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			29,895	29,895		29,895		29,895			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	327,049	72,607	212,857	612,513		612,513	(38,927)	573,586			45

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

Facility Name & ID Number Milestone-Searles

0027326

Report Period Beginning: 07/01/03

Ending: 06/30/04

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	(23,940)	34		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	(267)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>See Page 5-A</u>	(14,720)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (38,927)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (38,927)		37

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

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

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

OHF USE ONLY						
48		49		50		51
						52

Milestone-Searles

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Management Fee	\$ (4,320)	27	1
2	Maintenance Fee	(10,400)	7	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(14,720)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Milestone-Searles

0027326

Report Period Beginning:

07/01/03

Ending:

06/30/04

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	(10,400)	0	0	0	0	0	0	0	0	0	0	(10,400)	7
8	TOTAL General Services	(10,400)	0	0	0	0	0	0	0	0	0	0	(10,400)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(4,320)	0	0	0	0	0	0	0	0	0	0	(4,320)	27
28	TOTAL General Administration	(4,320)	0	0	0	0	0	0	0	0	0	0	(4,320)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(14,720)	0	0	0	0	0	0	0	0	0	0	(14,720)	29

STATE OF ILLINOIS

Facility Name & ID Number Milestone-Searles

0027326

Report Period Beginning:

07/01/03

Ending:

Summary B

06/30/04

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

	Capital Expense	PAGES	PAGE	SUMMARY									
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS
													(to Sch V, col.7)
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(267)	0	0	0	0	0	0	0	0	0	0	(267) 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	(23,940)	0	0	0	0	0	0	0	0	0	0	(23,940) 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	(24,207)	0	(24,207) 37									
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(38,927)	0	(38,927) 45									

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 Pages 24 & 25		See Pages 24 & 25				

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	See Page 28	\$			\$	\$	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.

Facility Name & ID Number Milestone-Searles # 0027326 Report Period Beginning: 07/01/03 Ending: 06/30/04

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ N/A		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

Facility Name & ID Number Milestone-Searles

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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 Milestone, Inc. - Central Office
 Street Address 4060 McFarland Road
 City / State / Zip Code Rockford, IL 61111
 Phone Number (815) 654-6100
 Fax Number (815) 654-6444

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary Wages	Days	57,670	4	\$ 235,145	\$ 235,145	4,380	\$ 17,859	1
2	1	Dietary Supplies	Days	113,880	31	48,267	0	4,380	1,856	2
3	2	Food Purchases	Days	113,880	31	951,986	0	4,380	36,615	3
4	3	Housekeeping Wages	Level of Care/Days	139,430	6	221,239	221,239	8,760	13,900	4
5	6	Maintenance Wages	Level of Care/Days	276,670	31	424,931	424,931	8,760	13,454	5
6	17	Administrative - Other	Level of Care/Days	8,834,400	36	330,963	0	315,360	11,814	6
7	21	Clerical Wages	Level of Care/Days	8,834,400	36	304,098	304,098	315,360	10,855	7
8	21	Office Supplies	Level of Care/Days	8,834,400	36	145,025	0	315,360	5,177	8
9	21	Telephone	Level of Care/Days	8,834,400	36	92,222	0	315,360	3,292	9
10	22	Fringe Benefits	Wages	13,942,578	37	2,448,834	0	327,049	57,442	10
11	35	Rent - Computer	Level of Care/Days	8,834,400	36	16,780	0	315,360	599	11
12	36	Rent - Maintenance Bldg	Level of Care/Days	8,834,400	36	7,837	0	315,360	280	12
13										13
14										14
15										15
16		See Addendum A								16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 5,227,327	\$ 1,185,413		\$ 173,143	25

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	U.S. Dept. of HUD		X	Mortgage	\$2,520.00	07/06/81	\$ 343,700	\$ 277,175	04/01/22	8.5000	\$ 23,812	1								
2	Amcore Bank		X	2001 Ford Van	\$790.00	03/01/01	24,983		03/10/04	8.5000	327	2								
3												3								
4												4								
5												5								
Working Capital																				
6	Amcore Bank		X	Line of Credit	N/A	07/23/01	5,000,000		01/10/05	4.0000	24	6								
7												7								
8												8								
9	TOTAL Facility Related				\$3,310.00		\$ 5,368,683	\$ 277,175			\$ 24,163	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 5,368,683	\$ 277,175			\$ 24,163	15								

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

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2003 report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	2
3. Under or (over) accrual (line 2 minus line 1).	\$	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1999	8
	2000	9
	2001	10
	2002	11
	2003	12

FOR OHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2003	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2003 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 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 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 2004 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,

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Milestone-Searles COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0027326

CONTACT PERSON REGARDING THIS REPORT Hugh W. Lippitt

TELEPHONE (815) 654-6100 FAX #: (815) 654-6444

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2003 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 2003.

(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. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES 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 original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004

Facility Name & ID Number Milestone-Searles

0027326 Report Period Beginning:

07/01/03 Ending:

06/30/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,800 B. General Construction Type: Exterior Brick Frame _____ Number of Stories one

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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Project</u>	<u>129,294</u>	<u>1982</u>	<u>\$ 17,914</u>	1
2					2
3	TOTALS	129,294		\$ 17,914	3

Facility Name & ID Number Milestone-Searles

0027326

Report Period Beginning:

07/01/03

Ending:

06/30/04

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	12		1982	1981	\$ 326,947	\$ 3,114	50	\$ 3,114	\$	\$ 242,875	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Roof			1993	5,025	251	20	251		2,722	9
10	Plumbing			1997	4,560	304	15	304		2,077	10
11	Smoke Detectors			1997	2,850	190	15	190		1,298	11
12	Blacktop			1997	5,188	346	15	346		2,017	12
13	Floor Repair			1997	625	25	25	25		146	13
14	Carpet			1997	4,063	580	7	580		3,386	14
15	Window Treatments			1997	1,291	129	10	129		742	15
16	Water Heater			2002	2,790	279	10	279		698	16
17	Patio Door			2003	2,845	190	15	190		206	17
18	Carpet			2004	3,101	221	7	221		221	18
19	Condenser			2004	3,105	52	10	52		52	19
20	Remodeling			2003	30,504	813	25	813		813	20
21	Deck & Railing			2004	9,137	38	20	38		38	21
22	Allocated Maintenance Building			1986	N/A	280	25	280		N/A	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.

See Page 12A, Line 70 for total

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

Facility Name & ID Number Milestone-Searles

0027326

Report Period Beginning:

07/01/03

Ending:

06/30/04

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 402,031	\$ 6,812		\$ 6,812	\$	\$ 257,291	70

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

Facility Name & ID Number Milestone-Searles # 0027326 Report Period Beginning: 07/01/03 Ending: 06/30/04

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	\$ 8,555	\$ 723	\$ 723	\$	10-15 yrs	\$ 5,062	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	34,868					34,868	73
74	Central Office Computer		599	599		10 yrs		74
75	TOTALS	\$ 43,423	\$ 1,322	\$ 1,322	\$		\$ 39,930	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	1995 Ford Van	1996	\$ 23,940	\$	\$	\$	3 yrs	\$ 23,940	76
77	Patient Care	2001 Ford Van	2001	24,983	4,858	4,858		3 yrs	24,983	77
78										78
79										79
80	TOTALS			\$ 48,923	\$ 4,858	\$ 4,858	\$		\$ 48,923	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)	\$ 512,291	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 12,992	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 12,992	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)	\$ 346,144	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: _____

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 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning _____
Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2005</u>	\$ _____
13.	<u>/2006</u>	\$ _____
14.	<u>/2007</u>	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34. _____

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

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

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

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF AIDES TRAINED

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

- (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.

- (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.

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

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

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

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 21,062	\$ 2,444,195	1
2	Cash-Patient Deposits	5,500	118,421	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	34,477	1,656,679	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		4,911	6
7	Other Prepaid Expenses		43,143	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>A/R Other</u>		15,015	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 61,039	\$ 4,282,364	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	17,914	1,304,389	13
14	Buildings, at Historical Cost	402,031	15,796,433	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	92,346	4,993,914	16
17	Accumulated Depreciation (book methods)	(346,145)	(11,296,337)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		115,573	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(112,434)	20
21	Restricted Funds		1,185,300	21
22	Other Long-Term Assets (spe Escrow & Loan fees)		705,967	22
23	Other(specify): <u>cash surrender value of life ins.</u>		32,478	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 166,146	\$ 12,725,283	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 227,185	\$ 17,007,647	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 10,218	\$ 408,595	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,500	118,421	28
29	Short-Term Notes Payable		14,060	29
30	Accrued Salaries Payable		572,307	30
31	Accrued Taxes Payable (excluding real estate taxes)		186,866	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	1,963	109,323	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Pension, Wrkmns Comp, Sec Dep, etc</u>	1,652	651,427	36
37	<u>Intercompany A/P</u>	96,624		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 115,957	\$ 2,060,999	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	277,175	2,762,999	40
41	Bonds Payable		3,560,000	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)	\$ 277,175	\$ 6,322,999	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 393,132	\$ 8,383,998	46
47	TOTAL EQUITY(page 18, line 24)	\$ (165,947)	\$ 8,623,649	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 227,185	\$ 17,007,647	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (156,866)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (156,866)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(9,081)	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)	\$ (9,081)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (165,947)	24 *

* This must agree with page 17, line 47.

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	\$ 519,949	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 519,949	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	41,532	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	23,940	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)	\$ 65,472	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	266	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 266	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Management/Maintenance Fee (see page 27)	14,720	28
28a	Gain on Sale of Vehicle	3,025	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 17,745	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 603,432	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	135,274	31
32	Health Care	282,555	32
33	General Administration	103,694	33
B. Capital Expense			
34	Ownership	61,095	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	29,895	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 612,513	40
41	Income before Income Taxes (line 30 minus line 40)**	(9,081)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (9,081)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. See Page 27

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

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

Facility Name & ID Number Milestone-Searles

0027326

Report Period Beginning:

07/01/03

Ending:

06/30/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	770	868	18,636	21.47	3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	578	647	10,758	16.63	11
12	Dietician					12
13	Food Service Supervisor	105	125	3,121	24.97	13
14	Head Cook					14
15	Cook Helpers/Assistants	1,326	1,465	14,738	10.06	15
16	Dishwashers					16
17	Maintenance Workers	889	1,006	13,454	13.37	17
18	Housekeepers	1,392	1,574	13,900	8.83	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	574	666	10,855	16.30	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	2,120	2,409	38,439	15.96	28
29	Resident Services Coordinator	693	801	12,033	15.02	29
30	Habilitation Aides (DD Homes)	15,977	17,631	191,115	10.84	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	24,424	27,192	\$ 327,049 *	\$ 12.03	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	15	\$ 435	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Dental	35	1,752	10-3	46
47	Clerical	45	550	21-3	47
48	Office Consultant	6	90	21-3	48
49	TOTAL (lines 35 - 48)	101	\$ 2,827		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number Milestone-Searles

0027326

Report Period Beginning: 07/01/03

Ending: 06/30/04

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	
			\$	Workers' Compensation Insurance	\$ 6,233	IDPH License Fee	\$ 1,000	
				Unemployment Compensation Insurance	616	Advertising: Employee Recruitment		
				FICA Taxes	23,880	Health Care Worker Background Check		
				Employee Health Insurance	18,256	(Indicate # of checks performed _____)		
				Employee Meals				
				Illinois Municipal Retirement Fund (IMRF)*				
				Pension	7,037			
				Employee Physical Exams	164			
				Other Employee Benefits	1,257			
TOTAL (agree to Schedule V, line 17, col. 1)			\$					
(List each licensed administrator separately.)								
B. Administrative - Other								
Description			Amount			Less: Public Relations Expense	()	
Administrator			\$ 3,961			Non-allowable advertising	()	
Assistant Administrator			2,960			Yellow page advertising	()	
Accountant			3,589					
Secretary			1,301					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 11,811	TOTAL (agree to Schedule V, line 22, col.8)	\$ 57,443	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 1,000	
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Lindgren, Callihan & VanOsdol	Audit		\$ 2,253				Out-of-State Travel	\$
Various	Computer Programming		236					
							In-State Travel	
							Seminar Expense	1,358
							See Page 26	
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)			\$ 2,489	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$ 1,358
(If total legal fees exceed \$2500 attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

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? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (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? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ N/A Line _____
- (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. _____
- (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. \$ 29,895
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? Yes
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. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Lindgren, Callihan & VanOsdol The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes 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? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SCHEDULE VII-A: BOARD MEMBER LISTING

<i>NAME</i>	<i>TITLE</i>	<i>TYPE OF SERVICE PROVIDED TO FACILITY</i>	<i>OWNERSHIP INTEREST IN</i>
Patrick Agnew	Director	Legal	Agnew Law Office
Ronald Alden	Director	Pension Accounting	McGladrey & Pullen
George Bass	Director	Insurance	Country Companies
Thomas Budd	Treasurer		
Lyla DeVerdi	Director	N/A	
Alan Furman	Director	N/A	
James Hamilton	President & C.E.O.	Administrative Services	
Peggy Hanson	Director	N/A	
Jack Kieckhefer	Director	Insurance	Kieckhefer & Nelson
Rick Powell	Secretary	N/A	
David Raht	Director	Insurance	Williams Manny
Tom Sandquist	Vice Chairperson	Legal	Williams & McCarthy
Shawn Way	Chairperson	Banking	Amcore Bank Rockford
Audrey Wickstrand	Director	N/A	

SCHEDULE VII-A: RELATED PARTIES

<u>MILESTONE, INC.</u>	<u>RESIDENTIAL BEDS</u>	<u>CITY</u>	<u>TYPE OF BUSINESS</u>
Central Office	N/A	Rockford	Central Office
Elmwood Heights	84	Rockford	ICF/MR-SLC
Elmwood East	12	Rockford	ICF/DD<16 & Fewer
Searles	12	Rockford	ICF/DD<16 & Fewer
Sun Valley	8	Rockford	ICF/DD<16 & Fewer
Javelin I	8	Rockford	C.R.A. - Waiver/C.I.L.A. Services
Applewood	8	Loves Park	C.R.A. - Waiver/C.I.L.A. Services
Belvidere*	8	Belvidere	C.R.A. - Waiver/C.I.L.A. Services
Orchard	8	Rockford	C.R.A. - Waiver/C.I.L.A. Services
Training Center	N/A	Rockford	Developmental Training
Industries	N/A	Loves Park	Developmental Training
RocVale Childrens Home	50	Rockford	Child Care Institute/DCFS
Dierks	8	Rockford	C.I.L.A. Services
C.I.L.A.	N/A	Rockford	C.I.L.A. Services
Windcloud	5	Rockford	C.I.L.A. Services
Prospect	5	Rockford	C.I.L.A. Services
Hanford	5	Rockford	C.I.L.A. Services
Rural	5	Rockford	C.I.L.A. Services
Flintridge	5	Rockford	C.I.L.A. Services
Old Golf	4	Loves Park	C.I.L.A. Services
Creekside	5	Rockford	C.I.L.A. Services
Javelin II	5	Rockford	C.I.L.A. Services
Windpoint	5	Rockford	C.I.L.A. Services
Riverside	5	Rockford	C.I.L.A. Services
Weymouth	5	Rockford	C.I.L.A. Services
Fleetwood	5	Rockford	C.I.L.A. Services
Stornway	5	Rockford	C.I.L.A. Services
Shiloh	4	Rockford	C.I.L.A. Services
Black Oak	5	Rockford	C.I.L.A. Services
Donna Drive	8	Rockford	C.I.L.A. Services
Respite Services	N/A	Rockford	Respite Services
Sawgrass	6	Rockford	C.I.L.A. Services
Crested Butte	6	Rockford	C.I.L.A. Services
Dental Program	N/A	Rockford	Dental Services
Thyme	6	Rockford	C.I.L.A. Services
Tulip	5	Rockford	C.I.L.A. Services
Packard	5	Rockford	C.I.L.A. Services
Country Club	5	Rockford	C.I.L.A. Services
HUD Project #071-EH003	N/A	Rockford	Housing
HUD Project #071-EH059	N/A	Rockford	Housing
HUD Project #071-EH178	N/A	Rockford	Housing
Bingo & Pull Tabs	N/A	Rockford	Bingo & Pull Tabs

* Closed 05/07/03

SCHEDULE OF TRAVEL AND SEMINAR EXPENSE

<u>EMPLOYEE NAME</u>	<u>JOB TITLE</u>	<u>DATES</u>	<u>SEMINAR LOCATION</u>	<u>SEMINAR TITLE</u>	<u>SEMINAR SPONSOR</u>	<u>CHECK #</u>	<u>COST</u>
1. Helen Pyfer Diane Nelson	QMRP/CRC Social Worker	7/10/03	Rockford, IL	Promoting Choices For Senior Caregivers of Adults with DD	NIAAA-Promoting Choices	83787	20.00
2. Kristine Lee Paola Cruz	QMRP QMRP	10/15/03	Peoria, IL	Basic Investigative Skills	Illinois Department of Human Services	86192	244.02
3. Jill Baker-Journy	Social Worker	1/13/04	Alsip, IL	QMRP Leadership Conference	The Arc of Illinois	86635	90.00
4. Ericka Sheely	QMRP	12/10/03	Itasca, IL	Preventing Abuse & Neglect	The Arc of Illinois	85782	100.00
5. Monica Young Theresa Risser	QMRP QMRP	12/10/03	Chicago, IL	Basic Investigative Skills	Illinois Department of Human Services	87084	196.85
6. Theresa Risser	QMRP	3/16/04	Tinley Park, IL	Behavioral Approaches	The Arc of Illinois	87509	100.00
7. Dixie Johnson	RN	4/21/04	Rockford, IL	2004 Illinois Nursing Law	Southwest Seminars	88138	59.00
8. Monica Young	QMRP	3/9/04	Rockford, IL	Dealing Effectively with Unacceptable Employee Behavior	Skillpath Seminars	87580	149.00
9. Tonia Phippen		1/15/04	Rockford, IL	English	Rock Valley College	86990	135.00
10. Ericka Sheely	QMRP	5/25/04 thru 5/27/04	Springfield, IL	Conference in Mental Health and Developmental Disabilities-Clinical Updates	SIU School of Medicine	89558	60.00
11. Dixie Johnson	RN	5/6/04	Joliet, IL	Religion in America	University of St. Francis	88752	<u>204.00</u>
						Total	<u><u>1,357.87</u></u>

Schedule of Federal Form 990 Reconciliation

Page 19, Line 41	(\$9,081)
Related Organizations Net Income	954,323
Federal Form 990 Net Income	<u><u>\$945,242</u></u>

NOTE: The U.S. Department of Housing and Urban Development (HUD) mandates that we maintain a separate general ledger for each project built with their funds. This report consolidates the Searles Program general ledger and the HUD Searles Building general ledger. This consolidation necessitates the following consolidation elimination entries for transactions between the two inter-related entities:

<u>Page</u>	<u>Line</u>	<u>Column</u>	<u>Description</u>	<u>DR / (CR)</u>
3	7	7	Maintenance Fee Expense	(10,400)
3	27	7	Management Fee Expense	(4,320)
19	28	1	Management/Maintenance Fee Revenue	14,720
4	34	7	Rent Expense - Facility	(23,940)
19	16	1	Rent Revenue - Facility	23,940

In compliance with the instructions, the following revenue items have been offset against expenses:

<u>Page</u>	<u>Line</u>	<u>Column</u>	<u>Description</u>	<u>DR / (CR)</u>
4	32	7	Interest Expense	(267)
19	25	1	Interest Income	267

RECLASSIFICATION - SCHEDULE V. COLUMN 5

SCHEDULE

V

<u>Line #</u>	<u>Title</u>	<u>Amount</u>
17	Administrative	(4,890.00)
21	Clerical	4,890.00
		<u>0</u>

To reclassify accountant & secretary from administrative personnel purchased at cost from Milestone Foundation, Inc.

30	Depreciation	599.00
35	Equipment Rent	(599.00)
		<u>0</u>

To reclassify rental of Computer from Milestone, Inc. Central Office.

30	Depreciation	280.00
36	Rent-Maintenance Building	(280.00)
		<u>0</u>

To reclassify rental of Maintenance Building from Milestone, Inc. Central Office.

**ADDENDUM
A**