

Facility Name & ID Number Searles Group Home

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

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	12	ICF/DD 16 or Less	12	4,380	6
7	12	TOTALS	12	4,380	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 Medicaid Recipient	4 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	4,348			4,348	13
14	TOTALS	4,348			4,348	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 99.27%

D. How many bed-hold days during this year were paid by the Department? 32 (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 2/11/82 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

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 06/30/07 Fiscal Year: 06/30/07

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

Facility Name & ID Number Searles Group Home # 0027326 Report Period Beginning: 07/01/06 Ending: 06/30/07

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

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	19,737	1,838	523	22,098		22,098		22,098		1
2	Food Purchase		40,461		40,461		40,461		40,461		2
3	Housekeeping	14,170	12,284	42	26,496		26,496		26,496		3
4	Laundry		78		78		78		78		4
5	Heat and Other Utilities			14,171	14,171		14,171		14,171		5
6	Maintenance	15,324	14,408	3,586	33,318		33,318		33,318		6
7	Other (specify):* Maintenance Fee			10,500	10,500		10,500	(10,500)			7
8	TOTAL General Services	49,231	69,069	28,822	147,122		147,122	(10,500)	136,622		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	273,700	2,072	1,842	277,614		277,614		277,614		10
10a	Therapy										10a
11	Activities		1,175		1,175		1,175		1,175		11
12	Social Services	11,830			11,830		11,830		11,830		12
13	CNA Training										13
14	Program Transportation		3,564	2,996	6,560		6,560		6,560		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	285,530	6,811	4,838	297,179		297,179		297,179		16
	C. General Administration										
17	Administrative	6,231		11,372	17,603	(4,618)	12,985		12,985		17
18	Directors Fees										18
19	Professional Services			2,693	2,693		2,693		2,693		19
20	Dues, Fees, Subscriptions & Promotions			300	300		300		300		20
21	Clerical & General Office Expenses	32,799	4,851	3,268	40,918	4,618	45,536	(127)	45,409		21
22	Employee Benefits & Payroll Taxes			64,499	64,499		64,499		64,499		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,651	5,651		5,651		5,651		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			5,201	5,201		5,201		5,201		26
27	Other (specify):* Management Fee			4,320	4,320		4,320	(4,320)			27
28	TOTAL General Administration	39,030	4,851	97,304	141,185		141,185	(4,447)	136,738		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	373,791	80,731	130,964	585,486		585,486	(14,947)	570,539		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.

Facility Name & ID Number

Searles Group Home

#0027326

Report Period Beginning:

07/01/06

Ending:

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			9,283	9,283	631	9,914		9,914			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			22,047	22,047		22,047	(83)	21,964			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			21,332	21,332		21,332	(21,332)				34
35	Rent-Equipment & Vehicles			2,437	2,437	(373)	2,064		2,064			35
36	Other (specify):* Alloc. Maint Bldg			258	258	(258)						36
37	TOTAL Ownership			55,357	55,357		55,357	(21,415)	33,942			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			31,420	31,420		31,420		31,420			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			31,420	31,420		31,420		31,420			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	373,791	80,731	217,741	672,263		672,263	(36,362)	635,901			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 Searles Group Home

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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	BHF 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	(21,332)	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	(83)	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	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>see page 5-A</u>	(14,947)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (36,362)		\$	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))	\$ (36,362)		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

BHF USE ONLY					
48		49		50	
				51	
					52

Searles Group Home

ID# 0027326

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Management Fee	\$ (4,320)	27	1
2	Maintenance Fee	(10,500)	7	2
3	Correct Allocation	(127)	21	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	(14,947)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Searles Group Home# 0027326

Report Period Beginning:

07/01/06

Ending:

06/30/07

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):*	(10,500)	0	0	0	0	0	0	0	0	0	0	(10,500)	7
8	TOTAL General Services	(10,500)	0	0	0	0	0	0	0	0	0	0	(10,500)	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	CNA 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	(127)	0	0	0	0	0	0	0	0	0	0	(127)	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	(4,447)	0	0	0	0	0	0	0	0	0	0	(4,447)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(14,947)	0	0	0	0	0	0	0	0	0	0	(14,947)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Searles Group Home# 0027326

Report Period Beginning:

07/01/06

Ending:

06/30/07

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

	Capital Expense	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)	
	D. Ownership													
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	(83)	0	0	0	0	0	0	0	0	0	0	(83)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(21,332)	0	0	0	0	0	0	0	0	0	0	(21,332)	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	(21,415)	0	0	0	0	0	0	0	0	0	0	(21,415)	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(36,362)	0	0	0	0	0	0	0	0	0	0	(36,362)	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 page 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

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0027326

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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 Searles Group Home

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

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	\$ 259,867	\$ 259,867	4,380	\$ 19,737	1
2	1	Dietary Supplies	Days	115,340	33	48,393		4,380	1,838	2
3	2	Food Purchases	Days	115,340	33	1,065,483		4,380	40,461	3
4	3	Housekeeping Wages	Level of Care/Days	139,430	6	225,532	225,532	8,760	14,170	4
5	6	Maintenance Wages	Level of Care/Days	279,590	33	489,105	489,105	8,760	15,324	5
6	17	Administrative - Other	Level of Care/Days	8,904,480	39	321,102		315,360	11,372	6
7	21	Clerical Wages	Level of Care/Days	8,904,480	39	300,512	300,512	315,360	10,643	7
8	21	Office Supplies	Level of Care/Days	8,904,480	39	133,373		315,360	4,724	8
9	21	Telephone	Level of Care/Days	8,904,480	39	86,635		315,360	3,068	9
10	22	Fringe Benefits	Wages	14,870,880	40	2,566,002		373,791	64,498	10
11	35	Rent - Computer	Level of Care/Days	8,904,480	39	10,537		315,360	373	11
12	36	Rent - Maintenance Bldg	Level of Care/Days	8,904,480	39	7,296		315,360	258	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					\$ 5,513,837	\$ 1,275,016		\$ 186,466	25

Facility Name & ID Number

Searles Group Home

0027326

Report Period Beginning:

07/01/06

Ending:

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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										
										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	7/6/81	\$ 343,700	\$ 254,454	4/1/22	8.5000	\$ 21,954	1							
2												2							
3												3							
4												4							
5												5							
Working Capital																			
6	Amcore Bank		X	Line of Credit	N/A	7/23/01	2,500,000		1/10/08	8.2500	93	6							
7												7							
8												8							
9	TOTAL Facility Related				\$2,520.00		\$ 2,843,700	\$ 254,454			\$ 22,047	9							
B. Non-Facility Related*																			
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 2,843,700	\$ 254,454			\$ 22,047	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 2006 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 2007 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:	2002	_____	8
	2003	_____	9
	2004	_____	10
	2005	_____	11
	2006	_____	12
	13	FROM R. E. TAX STATEMENT FOR 2006 \$	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.

Facility Name & ID Number Searles Group Home

0027326 Report Period Beginning:

07/01/06 Ending:

06/30/07

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, CNA 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:

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	12	1982	1981	\$ 326,947	\$ 3,114	50	\$ 3,114	\$	\$ 252,217	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Roof		1993	5,025	251	20	251		3,476	9
10	Plumbing		1997	4,560	304	15	304		2,989	10
11	Smoke Detectors		1997	2,850	190	15	190		1,868	11
12	Blacktop		1997	5,188	346	15	346		3,055	12
13	Floor Repair		1997	625	25	25	25		220	13
14	Carpet		1997	4,063		7			4,063	14
15	Window Treatments		1997	1,291	129	10	129		1,130	15
16	Water Heater		2002	2,789	279	10	279		1,534	16
17	Patio Door		2003	2,845	190	15	190		775	17
18	Carpet		2004	3,101	443	7	443		1,551	18
19	Condenser		2004	3,105	311	10	311		983	19
20	Replacement of doors & windows		2003	30,504	1,220	25	1,220		4,474	20
21	Deck & Railing		2004	9,137	457	20	457		1,409	21
22	Cabinets		2006	4,579	305	15	305		407	22
23	Kitchen Remodel		2006	3,170	211	15	211		282	23
24	Garage		2006	19,654	786	25	786		786	24
25	Allocated Maintenance Building		1986	n/a	258		258			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

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	TOTAL (lines 4 thru 69)	\$ 429,433	\$ 8,819		\$ 8,819	\$	\$ 281,219	70

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

Facility Name & ID Number Searles Group Home

0027326

Report Period Beginning:

07/01/06

Ending:

06/30/07

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	\$ 722	\$ 722	\$	10-15 yrs	\$ 7,229	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	34,868				5-10 yrs	34,868	73
74	Central Office Computer		373	373				74
75	TOTALS	\$ 43,423	\$ 1,095	\$ 1,095	\$		\$ 42,097	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	1997 Ford Van	1996	\$ 23,940	\$	\$	\$	3	\$ 23,940	76
77	Patient Care	2001 Ford Van	2001	24,983				3	24,983	77
78										78
79										79
80	TOTALS			\$ 48,923	\$	\$	\$		\$ 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)	\$ 539,693	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 9,914	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 9,914	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)	\$ 372,239	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

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? _____

16. Rental Amount for movable equipment: \$ 2,064 Description: Copier YES NO

(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

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. _____ /2008 \$ _____

13. _____ /2009 \$ _____

14. _____ /2010 \$ _____

* 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 CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

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

\$

D. NUMBER OF CNAs 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 CNA 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 CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs 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 CNAs.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
			Units	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 CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Searles Group Home# 0027326Report Period Beginning: 07/01/06Ending: 06/30/07

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/07

(last day of reporting year)

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	\$ 20,555	\$ 1,434,850	1
2	Cash-Patient Deposits	5,893	161,121	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	74,482	2,380,978	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		1,346	6
7	Other Prepaid Expenses		20,026	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Other A/R</u>	(160)	24,034	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 100,770	\$ 4,022,355	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	17,914	1,360,490	13
14	Buildings, at Historical Cost	429,433	17,489,684	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	92,346	5,558,035	16
17	Accumulated Depreciation (book methods)	(372,238)	(13,553,582)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		110,273	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(110,273)	20
21	Restricted Funds		1,347,000	21
22	Other Long-Term Assets (spe <u>Escrow & loan fees</u>)		4,103,941	22
23	Other(specify): <u>Value Life Ins. & Const. In prog</u>		223,691	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 167,455	\$ 16,529,259	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 268,225	\$ 20,551,614	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,208	\$ 478,716	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,893	161,121	28
29	Short-Term Notes Payable		161,803	29
30	Accrued Salaries Payable		561,636	30
31	Accrued Taxes Payable (excluding real estate taxes)		194,558	31
32	Accrued Real Estate Taxes(Sch.IX-B)		243	32
33	Accrued Interest Payable	1,802	173,933	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Pension,Wrkmsns Comp,Sec Dep,etc.</u>	1,523	571,951	36
37	<u>Intercompany A/P</u>	350,155		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 360,581	\$ 2,303,961	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	254,454	2,802,460	40
41	Bonds Payable		6,250,000	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)	\$ 254,454	\$ 9,052,460	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 615,035	\$ 11,356,421	46
47	TOTAL EQUITY(page 18, line 24)	\$ (346,810)	\$ 9,195,193	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 268,225	\$ 20,551,614	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (285,558)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (285,558)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(61,252)	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)	\$ (61,252)	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)	\$ (346,810)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Searles Group Home# 0027326Report Period Beginning: 07/01/06Ending: 06/30/07**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	\$ 527,422	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 527,422	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	47,757	10
11	CNA 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	20,929	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)	\$ 68,686	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	83	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 83	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Management/Maintenance Fee</u>	14,820	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 14,820	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 611,011	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	147,122	31
32	Health Care	297,179	32
33	General Administration	141,185	33
B. Capital Expense			
34	Ownership	55,357	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	31,420	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 672,263	40
41	Income before Income Taxes (line 30 minus line 40)**	(61,252)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (61,252)	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 **Searles Group Home**

0027326

Report Period Beginning:

07/01/06

Ending:

06/30/07

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	722	864	21,282	24.63	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	681	782	11,830	15.13	11
12	Dietician					12
13	Food Service Supervisor	92	119	3,059	25.71	13
14	Head Cook					14
15	Cook Helpers/Assistants	1,407	1,582	16,678	10.54	15
16	Dishwashers					16
17	Maintenance Workers	975	1,102	15,324	13.91	17
18	Housekeepers	1,326	1,511	14,170	9.38	18
19	Laundry					19
20	Administrator	166	191	6,231	32.62	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	539	621	10,643	17.14	23
24	Clerical	1,847	2,104	22,156	10.53	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	2,645	2,998	50,396	16.81	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	16,464	18,139	202,022	11.14	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	26,864	30,013	\$ 373,791 *	\$ 12.45	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	17	\$ 524	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) <u>Dental</u>	35	1,752	10-3	46
47	<u>Phlebotomist</u>	6	90	10-3	47
48	<u>Clerical</u>	14	200	21-3	48
49	TOTAL (lines 35 - 48)	72	\$ 2,566		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	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	\$		53

Facility Name & ID Number Searles Group Home

0027326

Report Period Beginning: 07/01/06

Ending: 06/30/07

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	
William Grahn	Administrator	0	\$ 6,231	Workers' Compensation Insurance	\$ 8,007	IDPH License Fee	\$	
				Unemployment Compensation Insurance	997	Advertising: Employee Recruitment		
				FICA Taxes	27,430	Health Care Worker Background Check		
				Employee Health Insurance	18,993	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Fees	300	
				Pension	7,541			
				Employee Physical Exams	477			
				Other Employee Benefits	883			
				Staff Applicant Referral Fee	171			
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						TOTAL (agree to Sch. V, line 20, col. 8)		
					\$ 64,499	\$ 300		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description				Description			Description	
Amount				Line #			Amount	
Administrator							Out-of-State Travel	
\$ 3,797							\$	
Assistant Administrator								
2,957								
Accountant							In-State Travel	
3,401								
Secretary								
1,217							Seminar Expense	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)							5,651	
							See page 26	
\$ 11,372								
							Entertainment Expense	
							()	
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				TOTAL			TOTAL	
\$ 2,693							\$ 5,651	

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Searles Group Home

0027326

Report Period Beginning: 07/01/06

Ending: 06/30/07

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? _____
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 during this cost report period. \$ 31,420
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, 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 \$5,000, 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

<u>NAME</u>	<u>TITLE</u>	<u>TYPE OF SERVICE PROVIDED TO FACILITY</u>	<u>OWNERSHIP INTEREST IN</u>
Patrick Agnew	Director	Legal	Agnew Law Office
Ronald Alden	Treasurer	Pension Accounting	McGladrey & Pullen
George Bass	Director	Insurance	Country Ins. & Financial Group
Thomas Budd	Vice Chairperson	N/A	Rockford Bank & Trust
Lyla DeVerdi	Director	N/A	
Alan Furman	Director	N/A	
James Hamilton	President & C.E.O.	Administrative Services	
Peggy Hanson	Secretary	N/A	
Jack Kieckhefer	Director	Insurance	Kieckhefer & Nelson
Cyrus Oates	Director	N/A	
Randy L. Cooper	Director	Insurance	Williams Manny
Tom Sandquist	Chairperson	Legal	Williams & McCarthy
Shawn Way	Director	N/A	Rockford Bank & Trust
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 (closed 8/15/06)	8	Rockford	C.R.A. - Waiver/C.I.L.A. Services
Applewood	8	Loves Park	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
Shattuck	5	Rockford	C.I.L.A. Services
Eggleston	5	Rockford	C.I.L.A. Services
Dierks	8	Rockford	C.I.L.A. Services
Geneva	5	Rockford	C.I.L.A. Services
C.I.L.A.	21	Rockford	C.I.L.A. Services
Auburn	9	Rockford	C.I.L.A. Services
Park Terrace	9	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
Hermitage	5	Rockford	C.I.L.A. Services
Javelin II	5	Rockford	C.I.L.A. Services
Windpoint	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

SCHEDULE OF TRAVEL & 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. Theresa Risser	Assist. Admin.	10/11/06 - 10/12/06	Springfield, IL	Corporate Compliance and Risk Mngmt Training	ICAN	103524	108.88
2. Dixie Johnson	Nurse	11/2/06	Rockford, IL	2006 Illinois Nursing Law	Southwest Seminars	102932	59.00
3. Dana Harmon	QMRP	3/19/07 - 3/20/07	Rockford, IL	The best friends Approach: A train the trainer program for improving Dementia Care	Alzheimers Association	104854	150.00
4. Theresa Risser	Assist. Admin.	2/21/07	Rockford, IL	Team-Building, Mentoring, and coaching skills for managers and supervisors	Fred Pryor Seminars	104384	179.00
5. Lisa Salazar	Social Worker	10/4/06	Rockford, IL	Challenging Geriatric Behaviors	PESI Healthcare	102276	169.00
6. Dixie Johnson	Nurse	2/19/07	Rockford, IL	Neurological Emergencies	PESI Healthcare	103686	169.00
7. Ericka Sheely	QMRP	8/9/06 - 8/11/06	San Antonio, TX	Serve Well: Tell the Story	Natl. Association of QMRP's	102164 102580	200.00 434.12
8. Linda Taylor Stacey Watkins	Team Leader Team Leader	11/28/06	Madison, WI	New Horizons in Dementia Care: Understanding the Disease and the person	UW-Madison	102828	240.00
9. Jessica Shipley	Direct Care staff	9/8/06	Rockford, IL	Intro Life Science General Psychology	Rock Valley College	102397 106645	244.00 183.00
10. Danielle Baron	Clerical Data	10/6/06 7/7/06 1/5/07 3/30/07	Rockford, IL	Pharmacology, Medical Keyboarding, Word Proc, Data Base Applications, Med. Asst. Externship Medical Comp.	Rockford Business College	102726 101347 104013 105243	1,727.00
11. Tonia Phippen	Team Leader	5/25/07	Rockford, IL	Elementary Algebra	Rock Valley College	106125	305.00
12. Danielle Baron	Clerical Data	5/4/07	Rockford, IL	Excel Pivot Tables Training Class	Entre Comp. Service	106082	135.00
13. Lisa Salazar	Social Worker	4/5/07	Rockford, IL	Paralegal Research	Rock Valley College	105401	61.00
14. Dana Harmon	QMRP	7/10/07 4/24/07	Chicago, IL Rockford, IL	4 day instructor certification Managing Emotions Under Pressure	Crisis Prevention Institute, Inc. Fred Pryor Seminars	106067 106478	1,199.00 88.00
						Total	<u>5,651.00</u>

Schedule of Federal Form 990 Reconciliation

Page 19, Line 41	(\$61,252)
Related Organizations Net Income	574,701
Federal Form 990 Net Income	\$513,449

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	(10,500)
3	27	7	Management Fee Expense	(4,320)
19	28	1	Management/Maintenance Fee Revenue	14,820
4	34	7	Rent Expense - Facility	(21,332)
19	16	1	Rent Revenue - Facility	21,332

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	(83)
19	25	1	Interest Income	83

RECLASSIFICATION - SCHEDULE V. COLUMN 5

SCHEDULE

V

<u>Line #</u>	<u>Title</u>	<u>Amount</u>
17	Administrative	(4,618.00)
21	Clerical	4,618.00
		<u>0</u>

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

30	Depreciation	373.00
35	Equipment Rent	(373.00)
		<u>0</u>

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

30	Depreciation	258.00
36	Rent-Maintenance Building	(258.00)
		<u>0</u>

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

**ADDENDUM
A**