

Facility Name & ID Number Rest Haven Illiana Christian

0007534 Report Period Beginning: 1/1/00 Ending: 12/31/00

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>95</u>	Skilled (SNF)	<u>95</u>	<u>34,770</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>98</u>	Intermediate (ICF)	<u>98</u>	<u>35,868</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>193</u>	TOTALS	<u>193</u>	<u>70,638</u>	7

B. Census-For the entire report period.

	1 Level of Care	3 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		2 Public Aid Recipient	Private Pay	4 Other		
8	SNF	<u>1,302</u>	<u>2,725</u>	<u>7,402</u>	<u>11,429</u>	8
9	SNF/PED					9
10	ICF	<u>30,822</u>	<u>22,076</u>		<u>52,898</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>32,124</u>	<u>24,801</u>	<u>7,402</u>	<u>64,327</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.07%

D. How many bed-hold days during this year were paid by Public Aid? 144 (Do not include bed-hold days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 02/10/60

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 27 and days of care provided 7,402

Medicare Intermediary Adminastar Federal

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/00 Fiscal Year: 12/31/00

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

STATE OF ILLINOIS

Facility Name & ID Number Rest Haven Illiana Christian # 0007534 Report Period Beginning: 1/1/00 Ending: 12/31/00

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7 **	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	434,903	62,353	18,095	515,351		515,351		515,351		1
2	Food Purchase		380,636		380,636		380,636	(18,052)	362,584		2
3	Housekeeping	209,296	25,057		234,353		234,353		234,353		3
4	Laundry	82,928	27,959		110,887		110,887	(7,908)	102,979		4
5	Heat and Other Utilities			152,637	152,637		152,637	3,017	155,654		5
6	Maintenance	82,896		162,565	245,461		245,461	(4,281)	241,180		6
7	Other (specify):*										7
8	TOTAL General Services	810,023	496,005	333,297	1,639,325		1,639,325	(27,224)	1,612,101		8
	B. Health Care and Programs										
9	Medical Director			14,400	14,400		14,400		14,400		9
10	Nursing and Medical Records	3,678,725	541,806	99,967	4,320,498		4,320,498		4,320,498		10
10a	Therapy		1,159	868,584	869,743		869,743	91,159	960,902		10a
11	Activities	95,029	21,088	285	116,402		116,402	(7,095)	109,307		11
12	Social Services	91,902		3,449	95,351		95,351		95,351		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,865,656	564,053	986,685	5,416,394		5,416,394	84,064	5,500,458		16
	C. General Administration										
17	Administrative	71,604		36,571	108,175		108,175	(36,571)	71,604		17
18	Directors Fees										18
19	Professional Services			35,878	35,878		35,878	1,989	37,867		19
20	Dues, Fees, Subscriptions & Promotions			57,353	57,353		57,353	(17,040)	40,313		20
21	Clerical & General Office Expenses	637,612	19,138	100,142	756,892		756,892	60,233	817,125		21
22	Employee Benefits & Payroll Taxes			648,552	648,552		648,552	79,153	727,705		22
23	Inservice Training & Education										23
24	Travel and Seminar			13,175	13,175		13,175	15,899	29,074		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			27,111	27,111		27,111	2,183	29,294		26
27	Other (specify):*										27
28	TOTAL General Administration	709,216	19,138	918,782	1,647,136		1,647,136	105,846	1,752,982		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,384,895	1,079,196	2,238,764	8,702,855		8,702,855	162,686	8,865,541		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

Facility Name & ID Number

Rest Haven Illiana Christian

#0007534

Report Period Beginning:

1/1/00

Ending:

12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7 **	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			608,276	608,276		608,276	(63,560)	544,716			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			154,610	154,610		154,610		154,610			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							9,516	9,516			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			762,886	762,886		762,886	(54,044)	708,842			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		456,330	48,355	504,685		504,685		504,685			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			104,220	104,220		104,220		104,220			42
43	Other (specify):* Nonallowable costs			415,070	415,070		415,070	(415,070)				43
44	TOTAL Special Cost Centers		456,330	567,645	1,023,975		1,023,975	(415,070)	608,905			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,384,895	1,535,526	3,569,295	10,489,716		10,489,716	(306,428)	10,183,288			45

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven Illiana Christian

0007534

Report Period Beginning: 1/1/00

Ending: 12/31/00

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(18,052)	2		4
5	Telephone, TV & Radio in Resident Rooms	(13,074)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(7,908)	4		8
9	Non-Straightline Depreciation	(93,444)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(279,320)	43		24
25	Fund Raising, Advertising and Promotional	(55,263)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(3,049)	43		28
29	Other-Attach Schedule See Attached Schedule 5A	(22,737)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (492,847)		\$	30

OHF USE ONLY					
48		49	50	51	52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	186,419		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 186,419		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (306,428)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

**Rest Haven Illiana Christian
Provider #: 0007534
12/31/2000**

Schedule 5A

VI. Adjustment Detail
Line 29, Other:

	<u>Amount</u>	<u>Line</u>
Capitalized fixed assets	(5,444)	6
Disallow Resident Welfare	(7,095)	11
Disallow Out of Period Legal	(165)	19
Disallow Dues	(55)	20
Disallow Training Dues	(21,100)	20
Out of State Travel/Seminar	(2,599)	24
Interehab Physiatry	(69,519)	43
Church/Civic	(4,906)	43
Trade Show	(1,809)	43
Directories	(368)	43
Development	(215)	43
Gift Gratuities	(621)	43
Therapy Adjustment	91,159	10a
Total	<u><u>(22,737)</u></u>	

SEE ACCOUNTANTS' COMPILATION REPORT

ID# 0007534
 Report Period Beginning: 11/00
 Ending: 12/31/00

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1			1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
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
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31			31
32			32
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41			41
42			42
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67			67
68			68
69			69
70			70
71			71
72			72
73			73
74			74
75			75
76			76
77			77
78			78
79			79
80			80
81			81
82			82
83			83
84			84
85			85
86			86
87			87
88			88
89			89
90	Total	0	90

Facility Name & ID Number Rest Haven Illiana Christian

0007534

Report Period Beginning:

1/1/00

Ending:

12/31/00

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
Rest Haven Illiana Christian Convalescent Home	100.00%	Rest Haven West Rest Haven South	Downers Grove South Holland	Holland Home Village Woods Saratoga Grove Providence Mgmt. Development Co. Providence Home Health Care	South Holland Crete Downers Grove South Holland South Holland	Sheltered Care Independent Ret. Sheltered Care Management Home Health

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	5 Utilities	\$	Rest Haven Illiana Christian Convalescent Home	100.00%	\$ 3,017	\$	3,017 1
2	V	6 Maintenance supplies		Rest Haven Illiana Christian Convalescent Home	100.00%	1,163		1,163 2
3	V	17 Administrative	36,571	Rest Haven Illiana Christian Convalescent Home	100.00%			(36,571) 3
4	V	19 Professional services		Rest Haven Illiana Christian Convalescent Home	100.00%	2,154		2,154 4
5	V	20 Dues, fees & subscriptions		Rest Haven Illiana Christian Convalescent Home	100.00%	4,115		4,115 5
6	V	21 Office		Rest Haven Illiana Christian Convalescent Home	100.00%	73,307		73,307 6
7	V	22 Employee benefits		Rest Haven Illiana Christian Convalescent Home	100.00%	79,153		79,153 7
8	V	24 Travel & seminar		Rest Haven Illiana Christian Convalescent Home	100.00%	18,498		18,498 8
9	V	26 Insurance		Rest Haven Illiana Christian Convalescent Home	100.00%	2,183		2,183 9
10	V	30 Depreciation		Rest Haven Illiana Christian Convalescent Home	100.00%	29,884		29,884 10
11	V	34 Rent		Rest Haven Illiana Christian Convalescent Home	100.00%	9,516		9,516 11
12	V							
13	V							
14	Total		\$ 36,571			\$ 222,990	\$ *	186,419 14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven Illiana Christian # 0007534 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$	1	
2										2	
3										3	
4										4	
5	N/A - Voluntary Board with no compensation. See attached Schedule 7A									5	
6										6	
7										7	
8										8	
9										9	
10										10	
11										11	
12										12	
13	TOTAL								\$		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 Rest Haven Illiana Christian # 0007534 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Rest Haven Illiana Christian Conv. Home
 Street Address 12450 West Cheshire Court
 City / State / Zip Code Lockport, IL 60441
 Phone Number (708) 645-2115
 Fax Number (708) 877-2103

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Accumulated Cost B	47,898,540	11	\$ 14,293	\$ 10,109,913	\$ 3,017	1
2	6	Maintenance Supplies	Accumulated Cost B	47,898,540	11	5,512	10,109,913	1,163	2
3	19	Professional Services	Accumulated Cost B	47,898,540	11	10,207	10,109,913	2,154	3
4	20	Fees, Subscriptions & Promotions	Accumulated Cost B	47,898,540	11	19,497	10,109,913	4,115	4
5	21	Clerical & General Office Exp.	Accumulated Cost B	47,898,540	11	347,138	10,109,913	73,270	5
6	21	Clerical & General Office Exp.	Accumulated Cost C	36,110,598	8	132	10,109,913	37	6
7	22	Employee Benefits	Accumulated Cost B	47,898,540	11	336,161	10,109,913	70,953	7
8	22	Employee Benefits	Direct Cost A	1	1	79,694	0	8,200	8
9	24	Travel & Seminar	Accumulated Cost B	47,898,540	11	87,639	10,109,913	18,498	9
10	26	Insurance-Prob. Liab. Malpractice	Accumulated Cost B	47,898,540	11	10,341	10,109,913	2,183	10
11	30	Depreciation	Accumulated Cost B	47,898,540	11	141,584	10,109,913	29,884	11
12	34	Rent - Facility & Grounds	Accumulated Cost B	47,898,540	11	45,086	10,109,913	9,516	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,097,284	\$	\$ 222,990	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven Illiana Christian # 0007534 Report Period Beginning: 1/1/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	Name of Lender	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		Tax Exempt Bond		x	Mortgage and additions	\$30,500(annual)	02/26/97	\$ 2,900,000	\$ 2,819,000	02/26/27	0.0485	\$ 153,600	1						
2													2						
3													3						
4													4						
5													5						
		Working Capital																	
6													6						
7													7						
8													8						
9		TOTAL Facility Related							\$ 2,900,000	\$ 2,819,000			\$ 153,600	9					
		B. Non-Facility Related*																	
10																			
11																			
12																			
13																			
14		TOTAL Non-Facility Related							\$	\$			\$ 1,010	14					
15		TOTALS (line 9+line14)							\$ 2,900,000	\$ 2,819,000			\$ 154,610	15					

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

(See instructions.)

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

(See instructions.)

Facility Name & ID Number Rest Haven Illiana Christian# 0007534

Report Period Beginning:

1/1/00

Ending:

12/31/00

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 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 2000 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.)	\$	N/A	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. 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 19 _____ 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:	1995	8	
	1996	9	
	1997	10	
	1998	11	
	1999	12	
FOR OFF USE ONLY			
	13	FROM R. E. TAX STATEMENT FOR 1999 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
This facility does not have real estate taxes because it is a not-for profit organization.	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven Illiana Christian

0007534 Report Period Beginning:

1/1/00 Ending:

12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 92,845 B. General Construction Type: Exterior Brick Frame Steel Number of Stories OneC. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

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

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

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

NoneF. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>	<u>441,662</u>	<u>1960</u>	<u>\$ 30,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	441,662		\$ 30,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven Illiana Christian

0007534

Report Period Beginning:

1/1/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	50			1960	\$ 341,041	\$ 8,526	40	\$ 8,526		\$ 349,566	4
5	50			1962	122,119	3,053	40	3,053		119,067	5
6				1963	86,546	2,164	40	2,164		82,332	6
7	93			1967	585,862	14,647	40	14,647		497,998	7
8				1975	147,301	3,683	40	3,683		95,737	8
	Improvement Type**										
9	Improvements			1967	312,475	7,812	40	7,812		262,714	9
10	Improvements			1970	74,824	1,871	40	1,871		58,001	10
11	Improvements			1971	10,740	269	40	269		8,070	11
12	Improvements			1972	3,992	100	40	100		2,900	12
13	Improvements			1973	2,002	50	40	50		1,367	13
14	Improvements			1974	1,001	25	40	25		655	14
15	Improvements			1976	8,418	210	40	210		5,140	15
16	Improvements			1977	1,073	27	40	27		630	16
17	Improvements			1979	450	11	40	11		242	17
18	Improvements			1980	629	16	40	16		336	18
19	Improvements			1982	3,077	77	40	77		1,463	19
20	Improvements			1983	4,063	102	40	102		1,836	20
21	Improvements			1984	11,366	284	40	284		4,828	21
22	Improvements			1985	5,552	139	40	139		2,224	22
23	Improvements			1986	308,545	7,714	40	7,714		115,710	23
24	Improvements			1987	242,285	6,057	40	6,057		84,798	24
25	Improvements			1988	144,720	3,618	40	3,618		35,702	25
26	Improvements			1989	75,090	1,877	40	1,877		22,515	26
27	Improvements			1990	258,016	6,450	40	6,450		74,330	27
28	Improvements			1991	88,476	2,212	40	2,212		23,852	28
29	Improvements			1992	51,572	1,289	40	1,289		11,601	29
30	Improvements			1993	283,946	7,099	40	7,099		57,381	30
31	Improvements			1994	396,618	9,915	40	9,915		70,419	31
32	Improvements			1995	207,113	5,526	40	5,526		29,662	32
33	Improvements			1995	13,913	928	15	928		5,104	33
34	Parking Lot Expansion			1996	74,714	1,868	40	1,868		8,406	34
35	Wing C & D Renovations			1996	226,501	5,662	40	5,662		25,479	35
36	TOTAL (lines 4 thru 35)				\$ 4,094,040	\$ 103,281		\$ 103,281		\$ 2,059,965	36

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rest Haven Illiana Christian# 0007534

Report Period Beginning:

1/1/00

Ending:

12/31/00**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Wing A & B Renovations	1996		279,308	6,982	40	6,982		31,419	9
10		Dental Office Renovations	1996		4,642	310	15	310		1,395	10
11		Lighting System	1996		49,263	1,232	40	1,232		5,544	11
12		Architect Fees	1996		13,512	338	40	338		1,521	12
13		Alarm System	1996		4,704	314	15	314		1,413	13
14		Whirlpool Renovation	1996		11,914	794	15	794		3,573	14
15		Door	1996		656	44	15	44		198	15
16		Book depr. for asset disallowed for medicaid				94,350			(94,350)		16
17		Unit I & II Renovation	1996		22,981	574	40	574		2,583	17
18		Landscaping	1997		5,984	398	15	398		1,393	18
19		Unit I A & B remodel:Carpentry, elec. plumb. etc (See Schedule 12E)	1997		236,778	9,472	25	9,472		33,152	19
20		Unit I C & D remodel:Carpentry, elec. plumb. etc(See Schedule 12E)	1997		211,804	8,472	25	8,472		29,652	20
21		Unit I Whirlpool Renovation	1997		3,264	130	25	130		455	21
22		Unit II Whirlpool Renovation	1997		3,910	156	25	156		546	22
23		Plumbing	1997		1,595	64	25	64		224	23
24		Unit II Laundry Room Cabinets	1997		729	30	25	30		105	24
25		Chapel Roof	1997		8,750	350	25	350		1,225	25
26		Ramp Entrance	1997		32,456	1,298	25	1,298		4,543	26
27		Employee Patio	1997		3,975	159	25	159		557	27
28		Ramp Curbing	1997		1,396	56	25	56		196	28
29		Stairwell Doors	1997		1,833	74	25	74		259	29
30		Handicap Ramp	1997		12,166	486	25	486		1,701	30
31		Medical Supply Room Renovation (See Schedule 12E)	1997		20,773	830	25	830		2,905	31
32		Unit II A & B remodel:Carpentry, fire protection (See Schedule 12E)	1997		78,500	3,140	25	3,140		10,990	32
33		A & B Basement Remodeling	1997		2,331	94	25	94		329	33
34		Unit II Storage Room	1997		3,458	138	25	138		483	34
35		Unit I A & B remodel:Carpentry, elec., tile (See Schedule 12E)	1998		18,389	736	25	736		11,750	35
36		TOTAL (lines 4 thru 35)			\$ 1,035,071	\$ 131,021		\$ 36,671	\$ (94,350)	\$ 148,111	36

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven Illiana Christian# 0007534

Report Period Beginning:

1/1/00

Ending:

12/31/00**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Unit II Handicap Ramp	1998		2,002	80	25	80		200	9
10		Unit II Storage Room	1998		8,807	352	25	352		880	10
11		Unit II A & B Bsmnt remodel:Carpty, elec, plumb, etc (See Sch12E)	1998		83,634	3,345	25	3,345		8,363	11
12		Unit I A & B remodel:Carpty,plmg, elec. (See Schedule 12E)	1998		19,906	796	25	796		1,990	12
13		Unit II A & B Bsmnt remodel:Carpty & fire prot. (See Schedule 12E)	1998		10,676	427	25	427		1,068	13
14		Design Plan for Renovation	1998		706	28	25	28		70	14
15		Unit II A & B Bsmnt remodel:Carpentry & fee (See Schedule 12E)	1998		2,314	93	25	93		232	15
16		Painting for Renovation	1998		3,873	154	25	154		385	16
17		Unit I A & B remodel:Carpty,& finishing etc. (See Schedule 12E)	1998		20,171	806	25	806		2,015	17
18		Carpeting	1998		13,997	2,800	5	2,800		7,000	18
19		Unit I A & B remodel:Carpty, plmg, fire etc (See Schedule 12E)	1998		8,026	322	25	322		805	19
20		Unit II Patio /Alzheimer's Garden	1998		49,519	1,980	25	1,980		4,950	20
21		Hot Water Heater	1998		831	56	15	56		140	21
22		Roof	1998		991	100	10	100		250	22
23		A/C Circulator	1998		1,115	74	15	74		185	23
24		Chimney Vent	1998		519	20	25	20		50	24
25		Fascia	1998		789	32	25	32		80	25
26		Smoke Detectors	1998		1,081	72	15	72		180	26
27		Speed Bumps for Parking Lot	1998		781	156	5	156		390	27
28		Heating & Cooling System	1998		34,826	1,394	25	1,394		3,485	28
29		Nurses' Alarm System	1998		13,917	556	25	556		1,390	29
30		Piping	1998		682	28	25	28		70	30
31		Patio	1999		10,472	262	40	262		393	31
32		Carpeting	1999		6,283	628	10	628		942	32
33		Electrical Generator	1999		66,394	6,640	10	6,640		9,960	33
34		Wall Firestopping	1999		15,000	1,500	10	1,500		2,250	34
35		Interior design fee	1999		228	22	10	22		33	35
36		TOTAL (lines 4 thru 35)			\$ 377,540	\$ 22,723		\$ 22,723	\$	\$ 47,756	36

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rest Haven Illiana Christian

0007534

Report Period Beginning:

1/1/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
		Improvement Type**									
9		Electrical	1999		4,383	438	10	438		657	9
10		Wall Firestopping	1999		35,000	3,500	10	3,500		5,250	10
11		Switchboard	1999		5,696	570	10	570		855	11
12		Landscaping	1999		48,376	1,210	10	1,210		1,815	12
13		Parking Lot	1999		8,610	216	40	216		324	13
14		Air Conditioners	1999		80,030	8,004	40	8,004		12,006	14
15		Boiler Repairs	1999		9,060		10	906	906	1,359	15
16		Landscaping	2000		10,704	356	15	356		356	16
17		Patio Shelter	2000		5,150	128	20	128		128	17
18		Garden	2000		7,768	258	15	258		258	18
19		Benches	2000		958	47	10	47		47	19
20		Lobby remodel: Plmg, finishing, wallpaper etc.(See Schedule 12E)	2000		102,660	5,133	10	5,133		5,133	20
21		Dining Room: Air cond. and electric (See Schedule 12E)	2000		6,269	208	15	208		208	21
22		Wing remodel:Carpty, elec, plmg, fire, etc (See Schedule 12E)	2000		102,095	1,276	40	1,276		1,276	22
23		Boiler and Pump	2000		10,450	348	15	348		348	23
24		Ansul	2000		3,728	124	15	124		124	24
25		Generator	2000		8,629	215	20	215		215	25
26		Fire Alarm System	2000		10,135	126	40	126		126	26
27		Exhaust Fan	2000		2,780	92	15	92		92	27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36		TOTAL (lines 4 thru 35)			\$ 462,481	\$ 22,249		\$ 23,155	\$ 906	\$ 30,577	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.

Facility Name & ID Number Rest Haven Illiana Christian

0007534

Report Period Beginning:

1/1/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											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	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 3,301,737	\$ 313,750	\$ 313,750		Various	\$ 2,683,489	37
38	Current Year Purchases	305,042	15,252	15,252		10 yrs	15,252	38
39	Fully Depreciated Assets							39
40	Home Office Allocation			29,884	29,884			40
41	TOTALS	\$ 3,606,779	\$ 329,002	\$ 358,886	\$ 29,884		\$ 2,698,741	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				\$	\$	\$	\$		\$	42
43										43
44										44
45										45
46	TOTALS			\$	\$	\$	\$		\$	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 9,605,911	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 608,276	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 544,716	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ (63,560)	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 4,985,150	51

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

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

G. Construction-in-Progress

	Description	Cost	
58	Land Improvements	\$ 3,800	58
59	Buiding	3,076	59
60	Equipment	20,331	60
61		\$ 27,207	61

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	Home Office Allocation				9,516			6
7	TOTAL				\$ 9,516			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>/2001</u>	\$ _____
13.	<u>/2002</u>	\$ _____
14.	<u>/2003</u>	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34. N/A
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: \$ N/A 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			\$ <u>N/A</u>	\$ _____	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	21

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

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

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

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

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p><i>It is the policy of this facility to only hire certified nurses aides.</i></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			
		1	2	3	4
		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.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10a, C8	hrs	\$	7,189	\$ 429,905	\$	7,189	\$ 429,905	1
2	Licensed Speech and Language Development Therapist	L10a, C8	hrs		1,949	156,364		1,949	156,364	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10a, C8	hrs		7,860	373,474	1,159	7,860	374,633	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescripts				456,330		456,330	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Schedule 16A	L39, C3				48,355			48,355	13
14	TOTAL			\$	16,998	\$ 1,008,098	\$ 457,489	16,998	\$ 1,465,587	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Rest Haven Illiana Christian
Provider #: 0007534
12/31/2000

Schedule 16A

Service	Schedule V Line & Column Reference	Cost
Radiology	L39, C3	17,720
Laboratory	L39, C3	<u>30,635</u>
		<u><u>48,355</u></u>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven Illiana Christian

0007534

Report Period Beginning: 1/1/00

Ending:

12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/00

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 8,027	\$ 8,027	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 414,867)	2,528,024	2,528,024	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	32,845	32,845	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,568,896	\$ 2,568,896	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	30,000	30,000	13
14	Buildings, at Historical Cost	5,970,434	5,969,132	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,568,267	3,606,779	16
17	Accumulated Depreciation (book methods)	(6,051,505)	(4,985,150)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Construction In Progress</u>		27,207	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,517,196	\$ 4,647,968	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,086,092	\$ 7,216,864	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,017,399	\$ 1,017,399	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	274,895	274,895	30
31	Accrued Taxes Payable (excluding real estate taxes)	88,482	88,482	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule 17A</u>	8,121,156	8,121,156	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 9,501,932	\$ 9,501,932	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable		2,819,000	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)	\$	\$ 2,819,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 9,501,932	\$ 12,320,932	46
47	TOTAL EQUITY(page 18, line 24)	\$ (3,415,840)	\$ (5,104,068)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,086,092	\$ 7,216,864	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Rest Haven Illiana Christian
Provider #: 0007534
12/31/2000

Schedule 17A

XV. Balance Sheet
C. Current Liabilities
Line 36, Other Current Liabilities

	<u>Operating</u>	<u>After Consolidaiton</u>
Provider Tax Reserves	(3,070)	(3,070)
Money Life Insurance Withholding	840	840
Levy	1,731	1,731
Credit Union Withholding	(763)	(763)
Due to Related Parties	8,122,418	8,122,418
Total	<u>8,121,156</u>	<u>8,121,156</u>

SEE ACCOUNTANTS' COMPILATION REPORT

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,148,995)	1
2	Restatements (describe):		2
3	Prior Year Adjustment per Auditor	(16,965)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,165,960)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(249,880)	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)	\$ (249,880)	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)	\$ (3,415,840)	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven Illiana Christian

0007534

Report Period Beginning: 1/1/00

Ending:

12/31/00

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 8,313,538	1
2	Discounts and Allowances for all Levels	(3,011,442)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,302,096	3
B. Ancillary Revenue			
4	Day Care	50,588	4
5	Other Care for Outpatients		5
6	Therapy	2,436,392	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,486,980	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	18,052	14
15	Telephone, Television and Radio	13,074	15
16	Rental of Facility Space		16
17	Sale of Drugs	478,516	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	40,297	19
20	Radiology and X-Ray	27,053	20
21	Other Medical Services	1,865,880	21
22	Laundry	7,908	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,450,780	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)		26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Recreation Hall Income	(20)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (20)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,239,836	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,639,325	31
32	Health Care	5,416,394	32
33	General Administration	1,647,136	33
B. Capital Expense			
34	Ownership	762,886	34
C. Ancillary Expense			
35	Special Cost Centers	919,755	35
36	Provider Participation Fee	104,220	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,489,716	40
41	Income before Income Taxes (line 30 minus line 40)**	(249,880)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (249,880)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

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

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

Facility Name & ID Number Rest Haven Illiana Christian

0007534

Report Period Beginning: 1/1/00

Ending:

12/31/00

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,032	2,080	\$ 49,435	\$ 23.77	1
2	Assistant Director of Nursing					2
3	Registered Nurses	52,719	57,121	1,126,809	19.73	3
4	Licensed Practical Nurses	24,936	27,021	454,706	16.83	4
5	Nurse Aides & Orderlies	168,919	183,336	2,007,198	10.95	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	8,438	9,054	95,029	10.50	10
11	Social Service Workers	7,252	7,933	91,902	11.58	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	41,370	44,730	434,903	9.72	15
16	Dishwashers					16
17	Maintenance Workers	5,500	5,729	82,896	14.47	17
18	Housekeepers	20,914	22,412	209,296	9.34	18
19	Laundry	7,779	8,403	82,928	9.87	19
20	Administrator	2,080	2,080	71,604	34.43	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	24,647	24,869	637,612	25.64	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,944	3,248	40,577	12.49	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	369,530	398,016	\$ 5,384,895 *	\$ 13.53	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	241	\$ 18,095	L1, C3	35
36	Medical Director	Monthly	14,400	L9, C3	36
37	Medical Records Consultant	Monthly	1,240	L10, C3	37
38	Nurse Consultant	Monthly	360	L10, C3	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	Monthly	285	L11, C3	44
45	Social Service Consultant	Monthly	333	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	241	\$ 34,713		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	303	\$ 12,119	L10, C3	50
51	Licensed Practical Nurses	3,253	81,318	L10, C3	51
52	Nurse Aides	329	4,930	L10, C3	52
53	TOTAL (lines 50 - 52)	3,885	\$ 98,367		53

SEE ACCOUNTANTS' COMPILATION REPORT

Rest Haven Illiana Christian
Provider #: 0007534
12/31/2000

Schedule 21A

XIX. Support Schedules
C. Professional Services

Total (agree to Schedule V, line 19, column 3)	35,878
Disallow out of period legal-Laner, Muchin, et al.	(165)
Home Office Allocation	2,154
	<hr/>
Total (agree to Schedule V, line 19, column 8)	<u>37,867</u>

SEE ACCOUNTANTS' COMPILATION REPORT

Rest Haven Illiana Christian
Provider #: 0007534
12/31/2000

Schedule 21B

XIX. Support Schedules
D. Employee Benefits and Payroll Taxes

	<u>Amount</u>
Met Life Retire Source	3,883
Guarantee Life Insurance	13,378
Fort Dearborn Life Insurance	1,508
Employee Outings	15,310
Service Pins	599
Name Tags	205
Miscellaneous Benefits	49,540
Total	<u><u>84,423</u></u>

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven Illiana Christian

0007534

Report Period Beginning:

1/1/00

Ending:

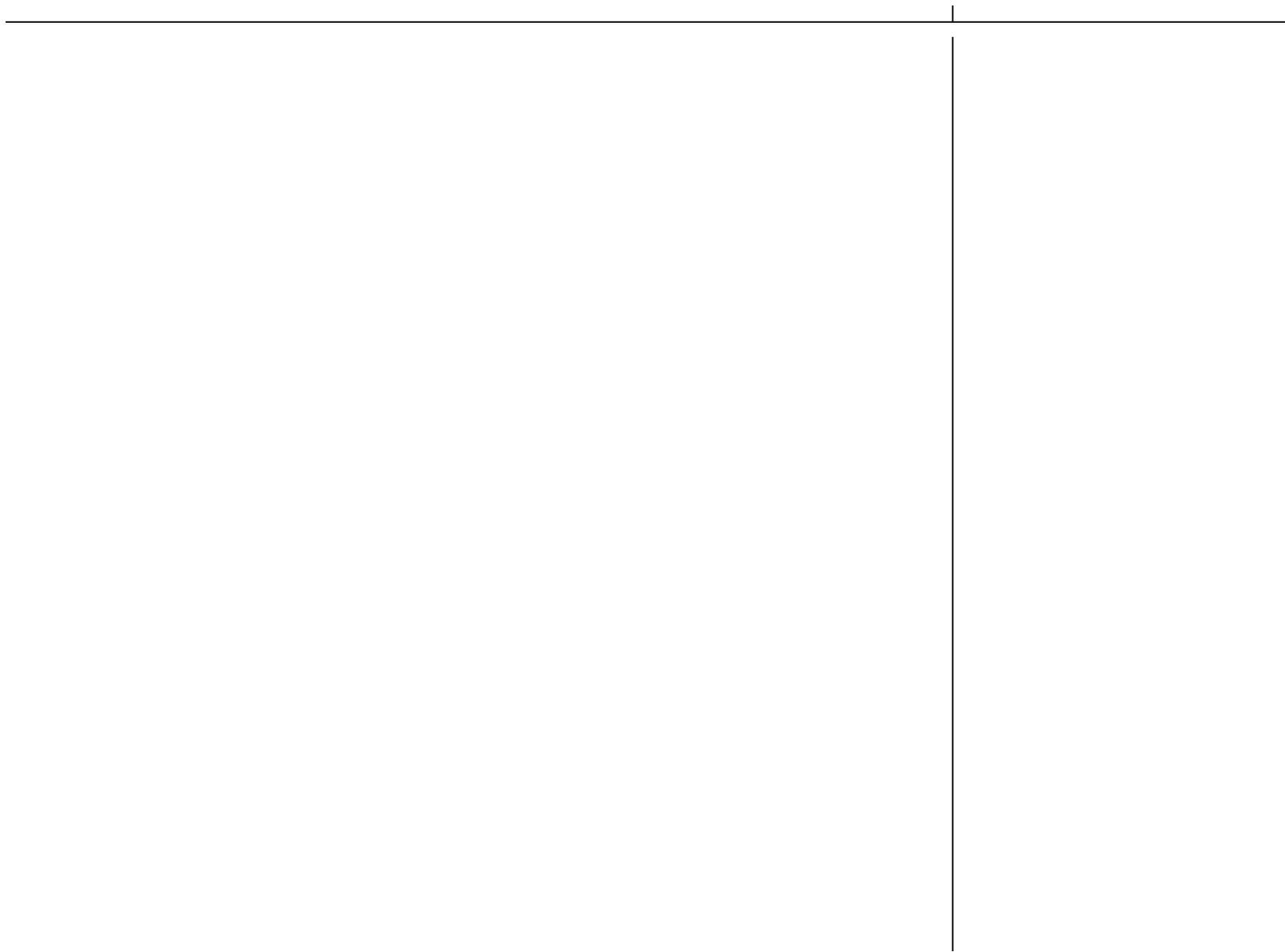
12/31/00

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. LSNI \$7,984; HRA \$10,850
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 80,414 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 104,220
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. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 18,052
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0%
d. Have vehicle usage logs been maintained? Adequate records are maintained
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: KPMG-Peat Marwick LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit in Progress
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT



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