

		FOR OHF USE				

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**2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)**

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

<p>I. IDPH Facility ID Number: <u>0007534</u></p> <p>Facility Name: <u>Rest Haven Central</u></p> <p>Address: <u>13259 South Central Avenue</u> <u>Palos Heights</u> <u>60463</u> Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(708) 597-1000</u> Fax # <u>(708) 389-9990</u></p> <p>IDPA ID Number: <u>362382853002</u></p> <p>Date of Initial License for Current Owners: <u>02/10/60</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code <u>501 (C) 3</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other</td> <td>_____</td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Christine Hanover</u> Telephone Number: <u>(312) 634-3400</u> Please send copies of desk review and audit adjustments to address on this page</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u>501 (C) 3</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	_____		<input type="checkbox"/> Limited Liability Co.	_____		<input type="checkbox"/> Trust	_____		<input type="checkbox"/> Other	_____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/03</u> to <u>12/31/03</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td data-bbox="1155 673 1291 820">Officer or Administrator of Provider</td> <td data-bbox="1291 673 1950 738">(Signed) _____ (Date) _____</td> </tr> <tr> <td data-bbox="1155 738 1291 820"></td> <td data-bbox="1291 738 1950 803">(Type or Print Name) _____</td> </tr> <tr> <td data-bbox="1155 803 1291 820"></td> <td data-bbox="1291 803 1950 868">(Title) _____</td> </tr> <tr> <td data-bbox="1155 820 1291 1031">Paid Preparer</td> <td data-bbox="1291 820 1950 885">(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____</td> </tr> <tr> <td data-bbox="1155 885 1291 1031"></td> <td data-bbox="1291 885 1950 950">(Print Name and Title) _____</td> </tr> <tr> <td data-bbox="1155 950 1291 1031"></td> <td data-bbox="1291 950 1950 1015">(Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u></td> </tr> <tr> <td data-bbox="1155 1015 1291 1031"></td> <td data-bbox="1291 1015 1950 1031">(Telephone) <u>(312) 634-3400</u> Fax # <u>(312) 634-5518</u></td> </tr> </table> <p align="right">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____		(Type or Print Name) _____		(Title) _____	Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____		(Print Name and Title) _____		(Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u>		(Telephone) <u>(312) 634-3400</u> Fax # <u>(312) 634-5518</u>
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven Central

0007534 Report Period Beginning: 01/01/03 Ending: 12/31/03

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	95	Skilled (SNF)	95	34,675	1
2		Skilled Pediatric (SNF/PED)			2
3	98	Intermediate (ICF)	98	35,770	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	193	TOTALS	193	70,445	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
		8	SNF	1,647	898	
9	SNF/PED					9
10	ICF	36,347	16,810	5	53,162	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	37,994	17,708	10,235	65,937	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.60%

D. How many bed-hold days during this year were paid by Public Aid? None (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 N/A NO

K. Was the facility certified for Medicare during the reporting year?
 YES NO If YES, enter number of beds certified 95 and days of care provided 9,515

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/03 Fiscal Year: 12/31/03

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

STATE OF ILLINOIS

Facility Name & ID Number Rest Haven Central # 0007534 Report Period Beginning: 01/01/03 Ending: 12/31/03

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
A. General Services											
1	Dietary	489,246	140,631	375	630,252		630,252		630,252		1
2	Food Purchase		384,277		384,277		384,277	(6,880)	377,397		2
3	Housekeeping	271,056	43,513		314,569		314,569		314,569		3
4	Laundry	94,721	31,774		126,495		126,495	(12,670)	113,825		4
5	Heat and Other Utilities			161,056	161,056		161,056	12,631	173,687		5
6	Maintenance	87,896		155,285	243,181		243,181	3,179	246,360		6
7	Other (specify):*										7
8	TOTAL General Services	942,919	600,195	316,716	1,859,830		1,859,830	(3,740)	1,856,090		8
B. Health Care and Programs											
9	Medical Director			15,000	15,000		15,000		15,000		9
10	Nursing and Medical Records	4,054,957	396,300	273,454	4,724,711		4,724,711		4,724,711		10
10a	Therapy			923,450	923,450		923,450	400,036	1,323,486		10a
11	Activities	100,165	10,087	1,763	112,015		112,015		112,015		11
12	Social Services	124,273		2,900	127,173		127,173		127,173		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,279,395	406,387	1,216,567	5,902,349		5,902,349	400,036	6,302,385		16
C. General Administration											
17	Administrative	63,944		427,515	491,459		491,459	(427,515)	63,944		17
18	Directors Fees										18
19	Professional Services			22,682	22,682		22,682	17,503	40,185		19
20	Dues, Fees, Subscriptions & Promotions			39,598	39,598		39,598	6,662	46,260		20
21	Clerical & General Office Expenses	754,253	32,752	133,541	920,546		920,546	45,904	966,450		21
22	Employee Benefits & Payroll Taxes			917,386	917,386		917,386	99,227	1,016,613		22
23	Inservice Training & Education							896	896		23
24	Travel and Seminar			10,624	10,624		10,624	14,034	24,658		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			95,812	95,812		95,812	7,660	103,472		26
27	Other (specify):*										27
28	TOTAL General Administration	818,197	32,752	1,647,158	2,498,107		2,498,107	(235,629)	2,262,478		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,040,511	1,039,334	3,180,441	10,260,286		10,260,286	160,667	10,420,953		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 Central

#0007534

Report Period Beginning:

01/01/03

Ending:

12/31/03

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			510,301	510,301		510,301	(43,303)	466,998			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			106,659	106,659		106,659	9,939	116,598			32
33	Real Estate Taxes							8,248	8,248			33
34	Rent-Facility & Grounds							3,530	3,530			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			616,960	616,960		616,960	(21,586)	595,374			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		672,147	322	672,469		672,469		672,469			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			106,644	106,644		106,644		106,644			42
43	Other (specify):* Nonallowable Costs			207,549	207,549		207,549	(207,549)				43
44	TOTAL Special Cost Centers		672,147	314,515	986,662		986,662	(207,549)	779,113			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,040,511	1,711,481	4,111,916	11,863,908		11,863,908	(68,468)	11,795,440			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

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	(9,274)	2		4
5	Telephone, TV & Radio in Resident Rooms	(14,641)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(12,670)	4		8
9	Non-Straightline Depreciation	(121,336)	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	(14,517)	43		24
25	Fund Raising, Advertising and Promotional	(69,992)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(10,546)	43		28
29	Other-Attach Schedule See attached Schedule 5A	284,091			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 31,115		\$	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)	(99,583)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (99,583)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (68,468)		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

Facility Name Rest Haven Central
PROVIDER # 0007534
Period Ending 12/31/2003

Schedule 5A

VI. ADJUSTMENT DETAIL
LINE 29 - Other

		Schedule V
<u>Description</u>	<u>Amount</u>	<u>Reference</u>
Disallow Chamber of Commerce dues	(190)	20
Interehab Physiatry	(69,525)	43
Medicare Ancillary X-ray	(16,756)	43
Medicare Lab Ancillary	(16,841)	43
Disallow out of state travel	(3,261)	24
Therapy Adjustment	400,036	10A
Disallow resident welfare	(9,372)	43
Total	<u><u>284,091</u></u>	

See Accountants' Compilation Report

Rest Haven Central

ID# 0007534

Report Period Beginning: 01/01/03

Ending: 12/31/03

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
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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	0	49

See Accountants' Compilation Report

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rest Haven Central

0007534

Report Period Beginning:

01/01/03

Ending:

12/31/03

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	(9,274)	2,394	0	0	0	0	0	0	0	0	0	(6,880)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(12,670)	0	0	0	0	0	0	0	0	0	0	(12,670)	4
5	Heat and Other Utilities	0	12,631	0	0	0	0	0	0	0	0	0	12,631	5
6	Maintenance	0	3,179	0	0	0	0	0	0	0	0	0	3,179	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(21,944)	18,204	0	(3,740)	8								
B. Health Care and Programs														
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
C. General Administration														
17	Administrative	0	(427,515)	0	0	0	0	0	0	0	0	0	(427,515)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	17,503	0	0	0	0	0	0	0	0	0	17,503	19
20	Fees, Subscriptions & Promotions	0	6,852	0	0	0	0	0	0	0	0	0	6,852	20
21	Clerical & General Office Expenses	(14,641)	60,545	0	0	0	0	0	0	0	0	0	45,904	21
22	Employee Benefits & Payroll Taxes	0	99,227	0	0	0	0	0	0	0	0	0	99,227	22
23	Inservice Training & Education	0	896	0	0	0	0	0	0	0	0	0	896	23
24	Travel and Seminar	0	17,295	0	0	0	0	0	0	0	0	0	17,295	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	7,660	0	0	0	0	0	0	0	0	0	7,660	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(14,641)	(217,537)	0	(232,178)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(36,585)	(199,333)	0	(235,918)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rest Haven Central

0007534

Report Period Beginning:

01/01/03

Ending:

12/31/03

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	(121,336)	78,033	0	0	0	0	0	0	0	0	0	(43,303)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	9,939	0	0	0	0	0	0	0	0	0	9,939	32
33	Real Estate Taxes	0	0	8,248	0	0	0	0	0	0	0	0	8,248	33
34	Rent-Facility & Grounds	0	0	3,530	0	0	0	0	0	0	0	0	3,530	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	(121,336)	87,972	11,778	0	(21,586)	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):*	(95,055)	0	0	0	0	0	0	0	0	0	0	(95,055)	43
44	TOTAL Special Cost Centers	(95,055)	0	0	0	0	0	0	0	0	0	0	(95,055)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(252,976)	(111,361)	11,778	0	(352,559)	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
Rest Haven Illiana Christian Convalescent Home	100	Rest Haven South	South Holland	Holland Home	South Holland	Sheltered Care
		Rest Haven West	Downers Grove	Village Woods	Crete	Independent Ret.
				Providence Mgmt. & Development Co.	Tinley Park	Management Co.
				Providence Home		
				Health Care	Tinley Park	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:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	2 Dietary	\$	Rest Haven Illiana Christian Convalescent Home	100.00%	\$ 2,394	\$ 2,394 1
2	V	5 Utilities		Rest Haven Illiana Christian Convalescent Home	100.00%	12,631	12,631 2
3	V	6 Maintenance		Rest Haven Illiana Christian Convalescent Home	100.00%	3,179	3,179 3
4	V	17 Administrative	427,515	Rest Haven Illiana Christian Convalescent Home	100.00%		(427,515) 4
5	V	19 Professional services		Rest Haven Illiana Christian Convalescent Home	100.00%	17,503	17,503 5
6	V	20 Dues, fees & subscriptions		Rest Haven Illiana Christian Convalescent Home	100.00%	6,852	6,852 6
7	V	21 Clerical & general office		Rest Haven Illiana Christian Convalescent Home	100.00%	60,545	60,545 7
8	V	22 Employee benefits		Rest Haven Illiana Christian Convalescent Home	100.00%	99,227	99,227 8
9	V	23 Inservice training & education		Rest Haven Illiana Christian Convalescent Home	100.00%	896	896 9
10	V	24 Travel & seminar		Rest Haven Illiana Christian Convalescent Home	100.00%	17,295	17,295 10
11	V	26 Insurance-prop, liab & malp.		Rest Haven Illiana Christian Convalescent Home	100.00%	7,660	7,660 11
12	V	30 Depreciation		Rest Haven Illiana Christian Convalescent Home	100.00%	78,033	78,033 12
13	V	32 Interest		Rest Haven Illiana Christian Convalescent Home	100.00%	9,939	9,939 13
14	Total		\$ 427,515			\$ 316,154	\$ * (111,361) 14

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

Facility Name & ID Number Rest Haven Central # 0007534 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization	Costs (7 minus 4)
15	V	33 Real estate taxes	\$	Rest Haven Illiana Christian Convalescent Home	100.00%	\$ 8,248	\$ 8,248	15
16	V	34 Rent-facility & grounds		Rest Haven Illiana Christian Convalescent Home	100.00%	3,530	3,530	16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 11,778	\$ * 11,778	39

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

Facility Name & ID Number Rest Haven Central # 0007534 Report Period Beginning: 01/01/03 Ending: 12/31/03

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	N/A - Voluntary Board with no compensation. See attached Schedule 7A										4
5										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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven Central

0007534 Report Period Beginning: 01/01/03

Ending: 12/31/03

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 18601 North Creek Drive
 City / State / Zip Code Tinley Park, IL 60477
 Phone Number (708) 342-8100
 Fax Number (708) 342-8006

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	2	Dietary	Accumulated cost	66,524,868	15	\$ 14,514	\$ 10,972,906	\$ 2,394	1
2	5	Utilities	Accumulated cost	66,524,868	15	76,578	10,972,906	12,631	2
3	6	Maintenance	Accumulated cost	66,524,868	15	19,273	10,972,906	3,179	3
4	19	Professional services	Accumulated cost	66,524,868	15	106,115	10,972,906	17,503	4
5	20	Dues, fees & subscriptions	Accumulated cost	66,524,868	15	41,544	10,972,906	6,852	5
6	21	Clerical & general office	Accumulated cost	66,524,868	15	367,063	10,972,906	60,545	6
7	22	Employee benefits	Accumulated cost	66,524,868	15	564,167	10,972,906	93,056	7
8	22	Employee benefits	Direct cost	1	11	74,415	1	6,171	8
9	23	Inservice training & education	Accumulated cost	66,524,868	15	5,434	10,972,906	896	9
10	24	Travel & seminar	Accumulated cost	66,524,868	15	104,854	10,972,906	17,295	10
11	26	Insurance-prop, liab & malp.	Accumulated cost	66,524,868	15	46,437	10,972,906	7,660	11
12	30	Depreciation	Accumulated cost	66,524,868	15	473,087	10,972,906	78,033	12
13	32	Interest	Accumulated cost	66,524,868	15	60,257	10,972,906	9,939	13
14	32	Interest-Providence	Direct cost	1	1	128,283	1	0	14
15	33	Real estate taxes	Accumulated cost	66,524,868	15	50,004	10,972,906	8,248	15
16	34	Rent-facility & grounds	Accumulated cost	66,524,868	15	21,400	10,972,906	3,530	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,153,425	\$	\$ 327,932	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven Central # 0007534 Report Period Beginning: 01/01/03 Ending: 12/31/03

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	
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Tax Exempt Bonds		X	Mortgage & Additions	Varies	2/26/97	\$ 2,900,000	\$ 2,670,500	02/26/27	0.0485	\$ 105,649	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 2,900,000	\$ 2,670,500			\$ 105,649	9	
	B. Non-Facility Related*												
10	Bond Issuance Related Interest											1,010	10
11													11
12									Home office allocation			9,939	12
13													13
14	TOTAL Non-Facility Related						\$	\$			\$ 10,949	14	
15	TOTALS (line 9+line14)						\$ 2,900,000	\$ 2,670,500			\$ 116,598	15	

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

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

** 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

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2002 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.)		\$	N/A 2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2003 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.	Allocated from Home Office		8,248
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.		\$	8,248 7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1998 _____	8	
	1999 _____	9	
	2000 _____	10	
	2001 _____	11	
	2002 _____	12	
Real estate taxes are allocated from a for-profit management entity.			
			FOR OHF USE ONLY
		13	FROM R. E. TAX STATEMENT FOR 2002 \$ 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.**

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rest Haven Central COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0007534

CONTACT PERSON REGARDING THIS REPORT Bill DeYoung

TELEPHONE (708) 342-8100 FAX #: (708) 348-8006

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2002.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>19-09-01-203-003-0000</u>	<u>New Home Office Building</u>	\$ <u>50,004.00</u>	\$ <u>8,248.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>50,004.00</u>	\$ <u>8,248.00</u>

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? X YES NO *See Page 8 for allocation*

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

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill whic is normally paid during 2003.

See Accountants' Compilation Report

Facility Name & ID Number Rest Haven Central

0007534 Report Period Beginning:

01/01/03 Ending:

12/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 92,845 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (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	Resident Care	441,662	1960	\$ 30,000	1
2					2
3	TOTALS	441,662		\$ 30,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven Central

0007534

Report Period Beginning:

01/01/03

Ending:

12/31/03

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	\$	40	\$	\$	\$ 341,041	4
5	50		1962	122,119		40			122,119	5
6			1963	86,546		40			86,546	6
7	93		1967	585,862	14,647	40	14,647		541,939	7
8			1975	147,301	3,683	40	3,683		106,786	8
Improvement Type**										
9	Improvements		1967	312,475	7,812	40	7,812		286,150	9
10	Improvements		1970	74,824	1,871	40	1,871		63,614	10
11	Improvements		1971	10,740	269	40	269		8,877	11
12	Improvements		1972	3,992	100	40	100		3,200	12
13	Improvements		1973	2,002	50	40	50		1,517	13
14	Improvements		1974	1,001	25	40	25		730	14
15	Improvements		1976	8,418	210	40	210		5,770	15
16	Improvements		1977	1,073	27	40	27		711	16
17	Improvements		1979	450	11	40	11		275	17
18	Improvements		1980	629	16	40	16		384	18
19	Improvements		1982	3,077	77	40	77		1,694	19
20	Improvements		1983	4,063	102	40	102		2,142	20
21	Improvements		1984	11,366	284	40	284		5,680	21
22	Improvements		1985	5,552	139	40	139		2,641	22
23	Improvements		1986	308,545	7,714	40	7,714		138,852	23
24	Improvements		1987	242,285	6,057	40	6,057		102,969	24
25	Improvements		1988	144,720	3,618	40	3,618		46,556	25
26	Improvements		1989	75,090	1,877	40	1,877		28,146	26
27	Improvements		1990	258,016	6,450	40	6,450		93,680	27
28	Improvements		1991	88,476	2,212	40	2,212		30,488	28
29	Improvements		1992	51,572	1,289	40	1,289		15,468	29
30	Improvements		1993	283,946	7,099	40	7,099		78,678	30
31	Improvements		1994	396,618	9,915	40	9,915		100,164	31
32	Improvements		1995	207,113	5,526	40	5,526		46,240	32
33	Improvements		1995	13,913	928	15	928		7,888	33
34	Parking Lot Expansion		1996	74,714	1,868	40	1,868		14,010	34
35	Wing C & D Renovations		1996	226,501	5,662	40	5,662		42,465	35
36	Wing A & B Renovations		1996	279,308	6,982	40	6,982		52,365	36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven Central

0007534

Report Period Beginning:

01/01/03

Ending:

12/31/03

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Dental Office Renovations	1996	\$ 4,642	\$ 310	15	\$ 310	\$	\$ 2,325		37
38	Lighting System	1996	49,263	1,232	40	1,232		9,240		38
39	Architect Fees	1996	13,512	338	40	338		2,535		39
40	Alarm System	1996	4,704	314	15	314		2,355		40
41	Whirlpool Renovation	1996	11,914	794	15	794		5,955		41
42	Door	1996	656	44	15	44		330		42
43	Unit I & II Renovation	1996	22,981	574	40	574		4,305		43
44	Landscaping	1997	5,984	398	15	398		2,587		44
45	Unit I A & B remodel:Carpentry, elec. Plumb	1997	236,778	9,472	25	9,472		61,569		45
46	Unit I C & D remodel:Carpentry, elec. plumb.	1997	211,804	8,472	25	8,472		55,068		46
47	Unit I Whirlpool Renovation	1997	3,264	130	25	130		845		47
48	Unit II Whirlpool Renovation	1997	3,910	156	25	156		1,014		48
49	Plumbing	1997	1,595	64	25	64		416		49
50	Unit II Laundry Room Cabinets	1997	729	30	25	30		195		50
51	Chapel Roof	1997	8,750	350	25	350		2,275		51
52	Ramp Entrance	1997	32,456	1,298	25	1,298		8,437		52
53	Employee Patio	1997	3,975	159	25	159		1,034		53
54	Ramp Curbing	1997	1,396	56	25	56		364		54
55	Stairwell Doors	1997	1,833	74	25	74		481		55
56	Handicap Ramp	1997	12,166	486	25	486		3,159		56
57	Medical Supply Room Renovation	1997	20,773	830	25	830		5,395		57
58	Unit II A & B remodel:Carpentry, fire protection	1997	78,500	3,140	25	3,140		20,410		58
59	A & B Basement Remodeling	1997	2,331	94	25	94		611		59
60	Unit II Storage Room	1997	3,458	138	25	138		897		60
61	Unit I A & B remodel:Carpentry, elec., file	1998	18,389	736	25	736		13,958		61
62	Unit II Handicap Ramp	1998	2,002	80	25	80		440		62
63	Unit II Storage Room	1998	8,807	352	25	352		1,936		63
64	Unit II A & B Bsmnt remodel:Carpty, elec, plumb.	1998	83,634	3,345	25	3,345		18,398		64
65	Unit I A & B remodel:Carpty,plmg, elec.	1998	19,906	796	25	796		4,378		65
66	Unit II A & B Bsmnt remodel:Carpty & fire prot.	1998	10,676	427	25	427		2,349		66
67	Design Plan for Renovation	1998	706	28	25	28		154		67
68	Unit II A & B Bsmnt remodel:Carpentry & fee	1998	2,314	93	25	93		511		68
69										69
70	TOTAL (lines 4 thru 69)		\$ 5,257,156	\$ 131,330		\$ 131,330	\$	\$ 2,613,711		70

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 Central

0007534

Report Period Beginning:

01/01/03

Ending:

12/31/03

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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12A, Carried Forward	\$ 5,257,156	\$ 131,330		\$ 131,330		\$ 2,613,711		1
2	Painting for Renovation	1998 3,873	154	25	154		847		2
3	Unit I A & B remodel:Carpty.& finishing	1998 20,171	806	25	806		4,433		3
4	Carpeting	1998 13,997	1,397	5	1,397		13,997		4
5	Unit I A & B remodel:Carpty, plmg, fire	1998 8,026	322	25	322		1,771		5
6	Unit II Patio /Alzheimer's Garden	1998 49,519	1,980	25	1,980		10,890		6
7	Hot Water Heater	1998 831	56	15	56		308		7
8	Roof	1998 991	100	10	100		550		8
9	A/C Circulator	1998 1,115	74	15	74		407		9
10	Chimney Vent	1998 519	20	25	20		110		10
11	Fascia	1998 789	32	25	32		176		11
12	Smoke Detectors	1998 1,081	72	15	72		396		12
13	Speed Bumps for Parking Lot	1998 781	79	5	79		781		13
14	Heating & Cooling System	1998 34,826	1,394	25	1,394		7,667		14
15	Nurses' Alarm System	1998 13,917	556	25	556		3,058		15
16	Piping	1998 682	28	25	28		154		16
17	Patio	1999 10,472	262	40	262		1,179		17
18	Carpeting	1999 6,283	628	10	628		2,826		18
19	Electrical Generator	1999 66,394	6,640	10	6,640		29,880		19
20	Wall Firestopping	1999 15,000	1,500	10	1,500		6,750		20
21	Interior design fee	1999 228	22	10	22		99		21
22	Electrical	1999 4,383	438	10	438		1,971		22
23	Wall Firestopping	1999 35,000	3,500	10	3,500		15,750		23
24	Switchboard	1999 5,696	570	10	570		2,565		24
25	Landscaping	1999 48,376	1,210	10	1,210		5,445		25
26	Parking Lot	1999 8,610	216	40	216		972		26
27	Air Conditioners	1999 80,030	8,004	40	8,004		36,018		27
28	Boiler Repairs	1999 9,060		10	906	906	4,078		28
29	Landscaping	2000 10,704	712	15	712		2,492		29
30	Patio Shelter	2000 5,150	256	20	256		896		30
31	Garden	2000 7,768	516	15	516		1,806		31
32	Benches	2000 958	94	10	94		329		32
33	Lobby remodel	2000 102,660	10,266	10	10,266		35,931		33
34	TOTAL (lines 1 thru 33)	\$ 5,825,046	\$ 173,234		\$ 174,140	\$ 906	\$ 2,808,243		34

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 Central

0007534

Report Period Beginning:

01/01/03

Ending:

12/31/03

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 5,825,046	\$ 173,234		\$ 174,140	\$ 906	\$ 2,808,243	1
2	Dining Room Renovation	2000	6,269	416	15	416		1,456	2
3	Wing Renovation	2000	102,095	2,552	40	2,552		8,932	3
4	Boiler and Pump	2000	10,450	696	15	696		2,436	4
5	Ansul	2000	3,728	248	15	248		868	5
6	Generator	2000	8,629	430	20	430		1,505	6
7	Fire Alarm System	2000	10,135	252	40	252		882	7
8	Exhaust Fan	2000	2,780	184	15	184		644	8
9	Landscaping	2001	5,680	1,136	5	1,136		2,840	9
10	Lobby remodel	2001	41,806	1,045	40	1,045		2,613	10
11	A-Wing remodel	2001	51,393	1,285	40	1,285		3,213	11
12	Sinks	2001	5,165	344	15	344		860	12
13	Doors	2001	5,278	352	15	352		880	13
14	Ejector Pump	2001	9,674	645	15	645		1,613	14
15	Automatic door	2001	4,817	688	7	688		1,720	15
16	Dining Room Renovation	2001	3,076	439	7	439		1,098	16
17	Exam Room Decoration	2001	14,068	2,010	7	2,010		5,025	17
18	Sewage Pump	2002	718	48	15	48		72	18
19	Whirlpool renovation	2002	2,177	145	15	145		218	19
20	Roof renovation	2002	90,250	9,025	10	9,025		13,538	20
21	Code Alert	2002	3,164	316	10	316		474	21
22	Firestopping work	2002	3,108	78	40	78		117	22
23	Dining Room Renovation	2002	135,527	3,388	40	3,388		5,082	23
24	Cabinets	2002	4,928	704	7	704		1,056	24
25	Blinds	2002	1,045	149	7	149		224	25
26	File cabinets	2002	2,327	332	7	332		498	26
27	Furniture	2002	1,814	259	7	259		389	27
28	Dining Room Renovation	2003	17,358	1,105	7	1,105		1,105	28
29	Lights	2003	20,442	511	20	511		511	29
30	Roof renovation	2003	152,000	7,600	10	7,600		7,600	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,544,947	\$ 209,616		\$ 210,522	\$ 906	\$ 2,875,712	34

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 Central

0007534

Report Period Beginning:

01/01/03

Ending:

12/31/03

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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12C, Carried Forward	\$ 6,544,947	\$ 209,616		\$ 210,522	\$ 906	\$ 2,875,712		1
2	Menu boards	2003 2,160	108	10	108		108		2
3	Carpeting	2003 5,957	426	7	426		426		3
4	Sliding doors	2003 2,100	105	10	105		105		4
5	Wander system	2003 21,630	1,051	20	1,051		1,051		5
6									6
7									7
8									8
9									9
10									10
11	Allocated from home office	2003 684,063	102,988		17,702	17,702	27,039		11
12	Book depreciation for assets not allowable for Medicaid					(102,988)			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	TOTAL (lines 1 thru 33)	\$ 7,260,857	\$ 314,294		\$ 229,914	\$ (84,380)	\$ 2,904,441		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,345,329	\$ 185,784	\$ 166,530	\$ (19,254)	Various	\$ 860,900	71
72	Current Year Purchases	204,456	10,223	10,223		5-15 years	10,223	72
73	Fully Depreciated Assets	2,498,083					2,498,083	73
74	Allocated from Home Office	542,720		58,516	58,516		236,802	74
75	TOTALS	\$ 4,590,588	\$ 196,007	\$ 235,269	\$ 39,262		\$ 3,606,008	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	Allocated from Home Office			\$ 9,448	\$	\$ 1,815	\$ 1,815		\$ 2,105	76
77										77
78										78
79										79
80	TOTALS			\$ 9,448	\$	\$ 1,815	\$ 1,815		\$ 2,105	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)	\$ 11,890,893	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 510,301	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 466,998	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (43,303)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,512,554	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	N/A				88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		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: 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*	7
3	Original Building:			\$			3
4	Additions						4
5							5
6	Home office allocation			3,530			6
7	TOTAL			\$ 3,530			7

10. Effective dates of current rental agreement:
 Beginning N/A
 Ending N/A

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2004</u>	\$ <u>N/A</u>
13.	<u>/2005</u>	\$ <u>N/A</u>
14.	<u>/2006</u>	\$ <u>N/A</u>

8. List separately any amortization of lease expense included on page 4, line 34.
 This amount was calculated by dividing the total amount to be amortized
 by the length of the lease N/A
N/A

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	7
17			\$	\$	17
18					18
19			<u>N/A</u>		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.

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 It is the policy of this facility to only hire certified nurses aides. 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: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> 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)	\$			

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

C. CONTRACTUAL INCOME

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

\$

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	

- (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	\$	7,531	\$ 513,685	\$	7,531	\$ 513,685	1
2	Licensed Speech and Language Development Therapist	L10a, C8	hrs		2,050	195,544		2,050	195,544	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10a, C8	hrs		8,109	614,257		8,109	614,257	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				672,147		672,147	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Laboratory	L39, C3				322			322	13
14	TOTAL			\$	17,690	\$ 1,323,808	\$ 672,147	17,690	\$ 1,995,955	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Rest Haven Central

0007534

Report Period Beginning: 01/01/03

Ending:

12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/03

(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	\$ 9,600	\$ 9,600	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 424,196)	2,110,276	2,110,276	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	36,554	36,554	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,156,430	\$ 2,156,430	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	6,579,297	7,260,857	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,145,629	4,600,036	16
17	Accumulated Depreciation (book methods)	(7,479,036)	(6,512,554)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,275,890	\$ 5,378,339	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,432,320	\$ 7,534,769	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,627,994	\$ 1,627,994	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	182	182	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	127,641	127,641	30
31	Accrued Taxes Payable (excluding real estate taxes)	60,699	60,699	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>Due to related parties</u>	7,694,981	5,024,481	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 9,511,497	\$ 6,840,997	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable		2,670,500	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)	\$	\$ 2,670,500	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 9,511,497	\$ 9,511,497	46
47	TOTAL EQUITY(page 18, line 24)	\$ (4,079,177)	\$ (1,976,728)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,432,320	\$ 7,534,769	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,893,259)	1
2	Restatements (describe):		2
3	Prior Period Adjustment	159,492	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,733,767)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(345,410)	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)	\$ (345,410)	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)	\$ (4,079,177)	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Rest Haven Central

0007534

Report Period Beginning: 01/01/03

Ending:

Page 19

12/31/03

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	\$ 10,027,105	1
2	Discounts and Allowances for all Levels	(3,507,664)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,519,441	3
B. Ancillary Revenue			
4	Day Care	48,100	4
5	Other Care for Outpatients		5
6	Therapy	3,310,223	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,358,323	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	9,274	14
15	Telephone, Television and Radio	14,641	15
16	Rental of Facility Space		16
17	Sale of Drugs	692,687	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	25,170	19
20	Radiology and X-Ray	24,145	20
21	Other Medical Services	860,780	21
22	Laundry	12,670	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,639,367	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	1,367	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,367	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,518,498	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,859,830	31
32	Health Care	5,902,349	32
33	General Administration	2,498,107	33
B. Capital Expense			
34	Ownership	616,960	34
C. Ancillary Expense			
35	Special Cost Centers	880,018	35
36	Provider Participation Fee	106,644	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,863,908	40
41	Income before Income Taxes (line 30 minus line 40)**	(345,410)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (345,410)	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 Central

0007534

Report Period Beginning: 01/01/03

Ending:

12/31/03

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	2,080	2,160	\$ 57,978	\$ 26.84	1
2	Assistant Director of Nursing	1,600	1,664	47,278	28.41	2
3	Registered Nurses	41,170	44,056	1,117,413	25.36	3
4	Licensed Practical Nurses	27,591	29,173	625,509	21.44	4
5	Nurse Aides & Orderlies	165,083	178,115	2,161,715	12.14	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,076	2,175	32,209	14.81	9
10	Activity Assistants	6,819	7,054	67,956	9.63	10
11	Social Service Workers	8,621	8,981	124,273	13.84	11
12	Dietician	1,941	2,021	44,915	22.22	12
13	Food Service Supervisor					13
14	Head Cook	2,016	2,080	31,542	15.16	14
15	Cook Helpers/Assistants	36,687	38,477	412,789	10.73	15
16	Dishwashers					16
17	Maintenance Workers	5,143	5,325	87,896	16.51	17
18	Housekeepers	24,558	26,222	271,056	10.34	18
19	Laundry	7,881	8,626	94,721	10.98	19
20	Administrator	2,080	2,080	63,944	30.74	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	34,168	36,642	754,253	20.58	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	2,798	3,286	45,064	13.71	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	372,312	398,137	\$ 6,040,511 *	\$ 15.17	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	Monthly \$ 375	L1, C3	35
36	Medical Director	Monthly 15,000	L9, C3	36
37	Medical Records Consultant	Monthly 1,104	L10, C3	37
38	Nurse Consultant	9 793	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	35 1,763	L11, C3	44
45	Social Service Consultant			45
46	Other(specify)			46
47	Chapel Ministry	Monthly 2,900	L12, C3	47
48				48
49	TOTAL (lines 35 - 48)	44 \$ 21,935		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	2,928 \$ 151,243	L10, C3	50
51	Licensed Practical Nurses	3,248 117,257	L10, C3	51
52	Nurse Aides	154 3,057	L10, C3	52
53	TOTAL (lines 50 - 52)	6,330 \$ 271,557		53

SEE ACCOUNTANTS' COMPILATION REPORT

Rest Haven Central
Provider #: 0007534
01/01/03 to 12/31/03

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3) 22,682

Allocated from Management Company

Legal 5,390

Other 12,113

Total (agree to Schedule V, line 19, column 8) 40,185

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									
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	
2			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	
3	N/A													
4														
5														
6														
7														
8														
9														
10														
11														
12														
13														
14														
15														
16														
17														
18														
19														
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven Central# 0007534Report Period Beginning: 01/01/03Ending: 12/31/03**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: \$15,767
- (3) Did the nursing home make political contributions or payments to a political 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 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 113,476 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 N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 106,644
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 benefit: on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 9,274
- (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 have been 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

RECONCILIATION REPORT

Rest Haven Central

01:04 PM 11/4/2005

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-68,468	equal to	-68,468	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	116,598	equal to	116,598	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	8,248	equal to	8,248	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	466,998	equal to	466,998	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	3,530	equal to	3,530	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	0	equal to	0	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	1,323,486	equal to	923,450	400,036	FAILED	Pg16 Z12+Z14...	N/A/B	14,40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	672,147	equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	1,859,830	equal to	1,859,830	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	5,902,349	equal to	5,902,349	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Administration	2,498,107	equal to	2,498,107	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	616,960	equal to	616,960	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	880,018	equal to	880,018	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24++	N/A	38b41+43	4
Income Stat. Prov. Partic.	106,644	equal to	106,644	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	4,054,957	equal to	4,054,957	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to	0	0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	100,165	equal to	100,165	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	124,273	equal to	124,273	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	489,246	equal to	489,246	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	87,896	equal to	87,896	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	271,056	equal to	271,056	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	94,721	equal to	94,721	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	63,944	equal to	63,944	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	754,253	equal to	754,253	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to	0	0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	6,040,511	equal to	6,040,511	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	375	< or = to	375	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	15,000	< or = to	15,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	273,454	< or = to	273,454	0	O.K.	Pg20 X14..X16+	B. & C.	37b39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	1,763	< or = to	1,763	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to	2,900	-2,900	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	63,944	equal to	63,944	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	427,515	equal to	427,515	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	22,682	equal to	22,682	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	1,016,613	equal to	1,016,613	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	46,260	equal to	46,260	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	24,658	equal to	24,658	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	106,644	equal to	106,644	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	< or = to	99,227	-99,227	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to	0	0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	9,515	equal to	10,230	-715	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-99,583	equal to	-99,583	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6l Y4f	B.	14	8
Total loan balance	2,670,500	equal to	2,670,500	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	0	equal to	0	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	30,000	equal to	30,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	7,260,857	equal to	7,260,857	0	O.K.	Pg12 to 12l L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	4,600,036	equal to	4,600,036	0	O.K.	Pg13 O22+L13	C. & D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	6,512,554	equal to	6,512,554	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-4,079,177	equal to	-4,079,177	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-345,410	equal to	-345,410	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to	0	0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	5,432,320	equal to	5,432,320	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

Capital Gains Data

Change year (Comment) _____

Facility Name _____

Real Estate Contact _____

USA No. _____

IF REATED, have facilities been continuously owned from an unincorporated entity since prior to January 1, 1975 (Y or N)? _____

IF REATED, have facilities been continuously owned from the first day of operation for building construction since January 1, 1975? _____

Client Report No. _____

Single _____

1989 Property Tax CODE: _____

1991 Property Tax RATE: _____

1991 Capital Gain _____

YOU MUST CHOOSE THE CAPITAL GAIN THAT IS LIMITED TO THE COST BASIS BY THE COST BASIS TABLE COSTS EXCLUDED ON PAGES 17 THROUGH 20 (PART A) CELL C-1

01/04/27 PM _____

CAPITAL CALCULATIONS

A. Determine the base year for your building from Work Table A

B. Determine the Building Specific historical cost per sq ft

C. Obtain Uniform Building Value from Table 1

D. The value will be calculated through a knowledge of the uniform building value from cost & the building specific historical cost per sq ft

E. Double the value from step D by 20% days to obtain a per cent historical value adjustment

F. Multiply the per cent historical value from step E by the applicable rate of return to obtain the building value factor. (The rate of return is 1% for 1979 and later years and 8 & 12% for 1970 and other base years)

G. Add Lines F & G to G to obtain the preliminary capital gain

H. Add Lines F & G to G to obtain the preliminary capital gain

I. Implementations Capital Rate. (This step does not apply if the facility has been constructed or purchased after 1/91)

J. Property Tax

K. Total Capital Gain for FY 94

L. Enter the greater of the capitalized system value from Line K or the historical value from Line J

M. Add Property Tax from Line J

N. Total capitalized value from Lines L & M

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	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	489,246	140,631	375	630,252	0	630,252	0	630,252
2. Food Purchase	0	384,277	0	384,277	0	384,277	-6,880	377,397
3. Housekeeping	271,056	43,513	0	314,569	0	314,569	0	314,569
4. Laundry	94,721	31,774	0	126,495	0	126,495	-12,670	113,825
5. Heat and Other Utilities	0	0	161,056	161,056	0	161,056	12,631	173,687
6. Maintenance	87,896	0	155,285	243,181	0	243,181	3,179	246,360
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	942,919	600,195	316,716	1,859,830	0	1,859,830	-3,740	1,856,090
9. Medical Director	0	0	15,000	15,000	0	15,000	0	15,000
10. Nursing & Medical Records	4,054,957	396,300	273,454	4,724,711	0	4,724,711	0	4,724,711
10a. Therapy	0	0	923,450	923,450	0	923,450	400,036	1,323,486
11. Activities	100,165	10,087	1,763	112,015	0	112,015	0	112,015
12. Social Services	124,273	0	2,900	127,173	0	127,173	0	127,173
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	4,279,395	406,387	1,216,567	5,902,349	0	5,902,349	400,036	6,302,385
17. Administrative	63,944	0	427,515	491,459	0	491,459	-427,515	63,944
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	22,682	22,682	0	22,682	17,503	40,185
20. Fees, Subscriptions & Promotion	0	0	39,598	39,598	0	39,598	6,662	46,260
21. Clerical & General Office	754,253	32,752	133,541	920,546	0	920,546	45,904	966,450
22. Employee Benefits & Payroll	0	0	917,386	917,386	0	917,386	99,227	1,016,613
23. Inservice Training & Education	0	0	0	0	0	0	896	896
24. Travel and Seminar	0	0	10,624	10,624	0	10,624	14,034	24,658
25. Other Admin. Staff Trans	0	0	0	0	0	0	0	0
26. Insurance-Prop.Liab.Malpractice	0	0	95,812	95,812	0	95,812	7,660	103,472
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	818,197	32,752	1,647,158	2,498,107	0	2,498,107	-235,629	2,262,478
29. Total General Administrative	6,040,511	1,039,334	3,180,441	10,260,286	0	10,260,286	160,667	10,420,953
30. Depreciation	0	0	510,301	510,301	0	510,301	-43,303	466,998
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	106,659	106,659	0	106,659	9,939	116,598
33. Real Estate	0	0	0	0	0	0	8,248	8,248
34. Rent - Facility & Grounds	0	0	0	0	0	0	3,530	3,530
35. Rent - Equipment & Vehicles	0	0	0	0	0	0	0	0
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	616,960	616,960	0	616,960	-21,586	595,374
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	672,147	322	672,469	0	672,469	0	672,469
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	106,644	106,644	0	106,644	0	106,644
43. Other (specify):*	0	0	207,549	207,549	0	207,549	-207,549	0
44. Total Special Cost Ce	0	672,147	314,515	986,662	0	986,662	-207,549	779,113
45. Grand Total	6,040,511	1,711,481	4,111,916	11,863,908	0	11,863,908	-68,468	11,795,440

	After	
	Operating	Consolidation
General Service Cost Center		
1. Cash on hand and in banks	9,600	9,600
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	2,110,276	2,110,276
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	0	0
7. Other Prepaid Expenses	36,554	36,554
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	0	0
10. Total current assets	2,156,430	2,156,430
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	30,000	30,000
14. Buildings, at Historical Cost	6,579,297	7,260,857
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	4,145,629	4,600,036
17. Accumulated Depreciation (book methods)	-7,479,036	-6,512,554
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	3,275,890	5,378,339
25. Total Assets	5,432,320	7,534,769
CURRENT LIABILITIES		
26. Accounts Payable	1,627,994	1,627,994
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	182	182
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	127,641	127,641
31. Accrued Taxes Payable	60,699	60,699
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	7,694,981	5,024,481
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	9,511,497	6,840,997
LONG TERM LIABILITES		
39. Long-Term Notes Payable	0	0
40. Mortgage Payable	0	0
41. Bonds Payable	0	2,670,500
42. Deferred Compensation	0	0
43. Other Long-Term Liabilities (specify):	0	0
44. Other Long-Term Liabilities (specify):	0	0
45. Total Long-Term Liabilities	0	2,670,500
46. Total Liabilities	9,511,497	9,511,497
47. Total Equity	-4,079,177	-1,976,728
48. Total Liabilities and Equity	5,432,320	7,534,769

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	10,027,105
2. Discounts and Allowances for all Levels	-3,507,664
Subtotal - Inpatient Care	6,519,441
4. Day Care	48,100
5. Other Care for Outpatients	0
6. Therapy	3,310,223
7. Oxygen	0
Subtotal - Ancillary Revenue	3,358,323
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	9,274
15. Telephone, Television, and Radio	14,641
16. Rental of Facility Space	0
17. Sale of Drugs	692,687
18. Sale of Supplies to Non-Patients	0
19. Laboratory	25,170
20. Radiology and X-Ray	24,145
21. Other Medical Services	860,780
22. Laundry	12,670
Subtotal - Other Operating Revenue	1,639,367
24. Contributions	0
25. Interest and Other Investments Income	0
Subtotal - Non-Operating Revenue	-
27. Other Revenue (specify):	1,367
28. Other Revenue (specify):	0
Subtotal - Other Revenue	1,367
30. Total Revenue	11,518,498
31. General Services	1,859,830
32. Health Care	5,902,349
33. General Administration	2,498,107
34. Ownership	616,960
35. Special Cost Centers	880,018
35. Provider Participation Fee	106,644
37. Other	0
40. Total Expenses	11,863,908
41. Income Before Income Taxes	-345,410
42. Income Taxes	0
43. Net Income or Loss for the Year	-345,410

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23 Provider Participation fee is linked from page 4