

		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><b>I. IDPH Facility ID Number:</b> <u>0023242</u></p> <p><b>Facility Name:</b> <u>Rest Haven South Nursing Home</u></p> <p><b>Address:</b> <u>16300 Wausau</u> <u>South Holland</u> <u>60473</u> Number City Zip Code</p> <p><b>County:</b> <u>Cook</u></p> <p><b>Telephone Number:</b> <u>(708) 596-5500</u> Fax # <u>(708) 877-4827</u></p> <p><b>IDPA ID Number:</b> <u>3623828530001</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>02/02/1977</u></p> <p><b>Type of Ownership:</b></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><b>IRS Exemption Code</b> <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><b>In the event there are further questions about this report, please contact:</b> 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	<b>IRS Exemption Code</b> <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><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>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) _____ (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 &amp; Address) <u>Altschuler, Melvojn 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, Melvojn 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 South Nursing Home

# 0023242 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	171	Skilled (SNF)	171	62,415	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	171	TOTALS	171	62,415	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		Public Aid Recipient	Private Pay	Other		
8	SNF	34,023	13,904	7,478	55,405	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	34,023	13,904	7,478	55,405	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.77%

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 02/02/1977

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 171 and days of care provided 7,478

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 South Nursing Home # 0023242 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
<b>A. General Services</b>											
1	Dietary	382,623	55,773	12,000	450,396		450,396		450,396		1
2	Food Purchase		340,762		340,762		340,762	(6,166)	334,596		2
3	Housekeeping	177,008	35,670		212,678		212,678		212,678		3
4	Laundry	113,841	19,063		132,904		132,904	(19,063)	113,841		4
5	Heat and Other Utilities			154,848	154,848		154,848	11,083	165,931		5
6	Maintenance	190,554		145,671	336,225		336,225	(19,091)	317,134		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	864,026	451,268	312,519	1,627,813		1,627,813	(33,237)	1,594,576		8
<b>B. Health Care and Programs</b>											
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	3,455,185	508,487	140,217	4,103,889		4,103,889		4,103,889		10
10a	Therapy		6,477	740,833	747,310		747,310	9,389	756,699		10a
11	Activities	116,001	16,246		132,247		132,247		132,247		11
12	Social Services	95,293	442	3,900	99,635		99,635		99,635		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	3,666,479	531,652	896,950	5,095,081		5,095,081	9,389	5,104,470		16
<b>C. General Administration</b>											
17	Administrative	91,111		430,308	521,419		521,419	(430,308)	91,111		17
18	Directors Fees										18
19	Professional Services			53,705	53,705		53,705	13,833	67,538		19
20	Dues, Fees, Subscriptions & Promotions			27,880	27,880		27,880	4,040	31,920		20
21	Clerical & General Office Expenses	622,681	30,030	72,095	724,806		724,806	41,470	766,276		21
22	Employee Benefits & Payroll Taxes			869,973	869,973		869,973	90,443	960,416		22
23	Inservice Training & Education							786	786		23
24	Travel and Seminar			9,448	9,448		9,448	12,302	21,750		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			91,935	91,935		91,935	6,721	98,656		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	713,792	30,030	1,555,344	2,299,166		2,299,166	(260,713)	2,038,453		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	5,244,297	1,012,950	2,764,813	9,022,060		9,022,060	(284,561)	8,737,499		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 &amp; ID Number

Rest Haven South Nursing Home

#0023242

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	
	<b>D. Ownership</b>											
30	Depreciation			455,552	455,552		455,552	(14,434)	441,118			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			164,529	164,529		164,529	8,721	173,250			32
33	Real Estate Taxes							7,237	7,237			33
34	Rent-Facility & Grounds							3,097	3,097			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			620,081	620,081		620,081	4,621	624,702			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		527,016		527,016		527,016		527,016			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			93,623	93,623		93,623		93,623			42
43	Other (specify):* <b>Nonallowable Costs</b>			262,530	262,530		262,530	(262,530)				43
44	<b>TOTAL Special Cost Centers</b>		527,016	356,153	883,169		883,169	(262,530)	620,639			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	5,244,297	1,539,966	3,741,047	10,525,310		10,525,310	(542,470)	9,982,840			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 South Nursing Home

# 0023242

Report Period Beginning: 01/01/03

Ending: 12/31/03

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	(8,267)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(19,063)	4		8
9	Non-Straightline Depreciation	(82,903)	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	(1,525)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(70,770)	43		24
25	Fund Raising, Advertising and Promotional	(67,267)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(12,204)	43		28
29	Other-Attach Schedule See Sch 5A	(141,281)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (403,280)		\$	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)	(139,190)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (139,190)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (542,470)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Rest Haven South Nursing Home

ID# 0023242

Report Period Beginning: 01/01/03

Ending: 12/31/03

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Offset Miscellaneous Revenue	\$ (11,655)	21	1
2	Disallow Public Relations	(5,685)	43	2
3	Disallow Lab Expense	(31,198)	43	3
4	Disallow Physiatry Expense	(69,525)	43	4
5	Disallow Residents Welfare	(5,881)	43	5
6	To capitalize repairs & maintenance	(20,444)	6	6
7	Deferred Maintenance	(1,436)	6	7
8	Disallow Out-of-State Seminar	(2,665)	24	8
9	Nonallowable Travel	(208)	24	9
10	Disallow Out-of-Period License & Dues	(1,973)	20	10
11	Marion Joy Therapy	9,389	10a	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(141,281)		49

See Accountants' Compilation Report

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Rest Haven South Nursing Home

# 0023242

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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(8,267)	2,101	0	0	0	0	0	0	0	0	0	(6,166)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(19,063)	0	0	0	0	0	0	0	0	0	0	(19,063)	4
5	Heat and Other Utilities	0	11,083	0	0	0	0	0	0	0	0	0	11,083	5
6	Maintenance	(21,880)	2,789	0	0	0	0	0	0	0	0	0	(19,091)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(49,210)</b>	<b>15,973</b>	<b>0</b>	<b>(33,237)</b>	<b>8</b>								
	<b>B. Health Care and Programs</b>													
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	9,389	0	0	0	0	0	0	0	0	0	0	9,389	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	<b>TOTAL Health Care and Programs</b>	<b>9,389</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>9,389</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(430,308)	0	0	0	0	0	0	0	0	0	(430,308)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,525)	15,358	0	0	0	0	0	0	0	0	0	13,833	19
20	Fees, Subscriptions & Promotions	(1,973)	6,013	0	0	0	0	0	0	0	0	0	4,040	20
21	Clerical & General Office Expenses	(11,655)	53,125	0	0	0	0	0	0	0	0	0	41,470	21
22	Employee Benefits & Payroll Taxes	0	90,443	0	0	0	0	0	0	0	0	0	90,443	22
23	Inservice Training & Education	0	786	0	0	0	0	0	0	0	0	0	786	23
24	Travel and Seminar	(2,873)	15,175	0	0	0	0	0	0	0	0	0	12,302	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	6,721	0	0	0	0	0	0	0	0	0	6,721	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(18,026)</b>	<b>(242,687)</b>	<b>0</b>	<b>(260,713)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(57,847)</b>	<b>(226,714)</b>	<b>0</b>	<b>(284,561)</b>	<b>29</b>								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rest Haven South Nursing Home # 0023242 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)	
	<b>D. Ownership</b>													
30	Depreciation	(82,903)	68,469	0	0	0	0	0	0	0	0	0	(14,434)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	8,721	0	0	0	0	0	0	0	0	0	8,721	32
33	Real Estate Taxes	0	0	7,237	0	0	0	0	0	0	0	0	7,237	33
34	Rent-Facility & Grounds	0	0	3,097	0	0	0	0	0	0	0	0	3,097	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	<b>TOTAL Ownership</b>	<b>(82,903)</b>	<b>77,190</b>	<b>10,334</b>	<b>0</b>	<b>4,621</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	(262,530)	0	0	0	0	0	0	0	0	0	0	(262,530)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(262,530)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(262,530)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(403,280)</b>	<b>(149,524)</b>	<b>10,334</b>	<b>0</b>	<b>(542,470)</b>	<b>45</b>							

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 Central	Palos Heights	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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)
1	V	2 Dietary	\$	Rest Haven Illiana Christian Convalescent Home	100.00%	\$ 2,101	\$ 2,101 1
2	V	5 Utilities		Rest Haven Illiana Christian Convalescent Home	100.00%	11,083	11,083 2
3	V	6 Maintenance		Rest Haven Illiana Christian Convalescent Home	100.00%	2,789	2,789 3
4	V	17 Administrative	430,308	Rest Haven Illiana Christian Convalescent Home	100.00%		(430,308) 4
5	V	19 Professional services		Rest Haven Illiana Christian Convalescent Home	100.00%	15,358	15,358 5
6	V	20 Dues, fees & subscriptions		Rest Haven Illiana Christian Convalescent Home	100.00%	6,013	6,013 6
7	V	21 Clerical & general office		Rest Haven Illiana Christian Convalescent Home	100.00%	53,125	53,125 7
8	V	22 Employee benefits		Rest Haven Illiana Christian Convalescent Home	100.00%	90,443	90,443 8
9	V	23 Inservice training & education		Rest Haven Illiana Christian Convalescent Home	100.00%	786	786 9
10	V	24 Travel & seminar		Rest Haven Illiana Christian Convalescent Home	100.00%	15,175	15,175 10
11	V	26 Insurance-prop, liab & malp.		Rest Haven Illiana Christian Convalescent Home	100.00%	6,721	6,721 11
12	V	30 Depreciation		Rest Haven Illiana Christian Convalescent Home	100.00%	68,469	68,469 12
13	V	32 Interest		Rest Haven Illiana Christian Convalescent Home	100.00%	8,721	8,721 13
14	Total		\$ 430,308			\$ 280,784	\$ * (149,524) 14

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

Facility Name & ID Number Rest Haven South Nursing Home # 0023242 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	4	5	6	7	8		
Schedule V	Line	Cost Per General Ledger Item	Amount	Cost to Related Organization Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Difference: Adjustments for Related Organization Costs (7 minus 4)		
15	V	33 Real estate taxes	\$	Rest Haven Illiana Christian Convalescent Home	100.00%	\$ 7,237	\$	7,237	15
16	V	34 Rent-facility & grounds		Rest Haven Illiana Christian Convalescent Home	100.00%	3,097		3,097	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		\$			\$ 10,334	\$ *	10,334	39

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

Facility Name & ID Number      Rest Haven South Nursing Home      #      0023242      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 South Nursing Home # 0023242 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	\$ 9,628,053	\$ 2,101	1
2	5	Utilities	Accumulated cost	66,524,868	15	76,578	9,628,053	11,083	2
3	6	Maintenance	Accumulated cost	66,524,868	15	19,273	9,628,053	2,789	3
4	19	Professional services	Accumulated cost	66,524,868	15	106,115	9,628,053	15,358	4
5	20	Dues, fees & subscriptions	Accumulated cost	66,524,868	15	41,544	9,628,053	6,013	5
6	21	Clerical & general office	Accumulated cost	66,524,868	15	367,063	9,628,053	53,125	6
7	22	Employee benefits	Accumulated cost	66,524,868	15	564,167	9,628,053	81,651	7
8	22	Employee benefits	Direct cost	1	11	74,415	1	8,792	8
9	23	Inservice training & education	Accumulated cost	66,524,868	15	5,434	9,628,053	786	9
10	24	Travel & seminar	Accumulated cost	66,524,868	15	104,854	9,628,053	15,175	10
11	26	Insurance-prop, liab & malp.	Accumulated cost	66,524,868	15	46,437	9,628,053	6,721	11
12	30	Depreciation	Accumulated cost	66,524,868	15	473,087	9,628,053	68,469	12
13	32	Interest	Accumulated cost	66,524,868	15	60,257	9,628,053	8,721	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	9,628,053	7,237	15
16	34	Rent-facility & grounds	Accumulated cost	66,524,868	15	21,400	9,628,053	3,097	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,153,425	\$	\$ 291,118	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven South Nursing Home # 0023242 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 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	<b>A. Directly Facility Related</b>											
	<b>Long-Term</b>											
1	Individual Notes		X	Building Improvements	Varies	Varies	\$ 70,321	\$ 9,321	Varies	Varies	\$ 3,570	1
2	Tax Exempt Bonds		X	Building	Varies	02/26/97	2,633,850	2,403,450	02/26/27	Varies	160,959	2
3												3
4												4
5												5
	<b>Working Capital</b>											
6												6
7												7
8												8
9	<b>TOTAL Facility Related</b>						\$ 2,704,171	\$ 2,412,771			\$ 164,529	9
	<b>B. Non-Facility Related*</b>											
10												10
11											8,721	11
12												12
13												13
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 8,721	14
15	<b>TOTALS (line 9+line14)</b>						\$ 2,704,171	\$ 2,412,771			\$ 173,250	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.)



**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 South Nursing Home COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0023242

CONTACT PERSON REGARDING THIS REPORT Bill DeYoung

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

**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>7,237.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>50,004.00</u>	\$ <u>7,237.00</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?  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 Real estate taxes are accrued, bill has not yet been received on the new buildin**

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 65,000 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's 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)

None

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

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A  
 3. 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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	Facility	Not available	1976	\$ 31,305	1
2					2
3	TOTALS			\$ 31,305	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven South Nursing Home

# 0023242

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	171	1977	1977	\$ 2,657,266	\$ 66,432	40	\$ 66,432	\$	\$ 1,724,543	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Landscaping Improvements		1977	19,723		20			19,723	9
10	Building Improvements		1978	7,401		40	185	185	2,819	10
11	Land Improvements		1981	2,535		20			2,535	11
12	Building Improvements		1982	8,179		40	204	204	4,309	12
13	Building Improvements		1983	4,035		40	101	101	2,030	13
14	Land Improvements		1984	7,625	381	20	381		7,315	14
15	Building Improvements		1985	2,029		40	51	51	923	15
16	Building Improvements		1986	49,092		40	1,227	1,227	21,090	16
17	Building Improvements		1987	48,670		40	1,217	1,217	19,726	17
18	Land Improvements		1987	4,898	245	20	245		3,981	18
19	Building Improvements		1988	21,602	1,428	40	540	(888)	8,228	19
20	Land Improvements		1988	1,600	80	20	80		1,222	20
21	Building Improvements		1898	561,415	14,035	40	14,035		200,160	21
22	Land Improvements		1898	9,437	472	20	472		6,746	22
23	Building Improvements		1990	98,412	6,561	40	2,460	(4,101)	32,688	23
24	Building Improvements		1991	74,357	4,957	40	1,859	(3,098)	22,887	24
25	Building Improvements		1992	168,370	4,209	40	4,209		47,717	25
26	Land Improvements		1992	13,785	689	20	689		7,829	26
27	Building Improvements		1994	24,717	1,648	40	618	(1,030)	5,801	27
28	Building Improvements		1995	52,042	3,469	40	1,301	(2,168)	11,058	28
29	Land Improvements		1995	10,722	536	20	536		4,556	29
30	Landscaping		1996	20,214	1,347	20	1,010	(337)	7,273	30
31	Building Redecorating		1996	15,578	1,039	40	390	(649)	3,065	31
32	Building Improvement - Ceiling		1996	25,000	1,667	40	625	(1,042)	4,427	32
33	Building Improvements - HVAC		1996	5,000		40	125	125	885	33
34	Landscaping		1997	27,690	1,846	20	1,349	(497)	8,944	34
35	Building Resident Room Redecorating		1997	64,348	4,290	40	1,609	(2,681)	10,265	35
36	Building - Ceiling & Lighting		1997	62,447	3,663	40	1,561	(2,102)	10,574	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 &amp; ID Number Rest Haven South Nursing Home

# 0023242

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	Building Fire Alarm System	1997	\$ 4,483	\$ 640	40	\$ 112	\$ (528)	\$ 765	37
38	Building - HVAC	1997	43,720	2,915	40	1,093	(1,822)	7,378	38
39	Building Improvement Resident Rooms in Gilead Area	1997	44,208	2,947	40	1,105	(1,842)	6,692	39
40	Building - Elevator Repair	1997	12,780	852	40	320	(532)	2,153	40
41	Building - Beauty Shop Renovation	1997	1,800	120	40	45	(75)	278	41
42	Land Improvement - Parking Lot	1998	46,302	2,315	20	2,316	1	12,738	42
43	Building Improvement Resident Rooms in Gilead Area	1998	34,374	2,338	40	859	(1,479)	4,725	43
44	Building - HVAC	1998	40,850	2,723	40	1,021	(1,702)	5,616	44
45	Building Rehab. Area	1998	68,738	4,455	40	1,718	(2,737)	9,449	45
46	Building - Kitchen Fan	1999	1,400	93	40	35	(58)	158	46
47	Building Therapy Room Renovation	1999	2,083	139	40	52	(87)	234	47
48	Building Improvement HVAC	2000	801,268	54,236	40	20,032	(34,204)	80,128	48
49	Building Improvement Social Service Office	2000	1,683	240	7	240		840	49
50	Land Improvement - Lighting	2000	30,000	2,000	15	2,000		7,000	50
51	Land Improvement - Fencing	2000	8,071	538	15	538		1,883	51
52	Building Improvement HVAC	2000	663,243	43,915	40	16,581	(27,334)	58,034	52
53	Building - Garage	2000	3,820	382	20	191	(191)	669	53
54	Building Improvement - Pipe Enclosure	2000	82,716	11,817	40	2,068	(9,749)	7,238	54
55	Building Improvement - Tile in Kitchen place into service 2001	2001	6,800	971	7	971		2,913	55
56	Land Improvement - Light Poles	2001	1,878		15	125	125	312	56
57	Building Improvements - HVAC	2001	19,808	822	40	495	(327)	1,238	57
58	Building Improvements - Kitchen Floor	2001	35,884	2,392	15	2,392		5,980	58
59	Building Improvements - Fire Protection System	2001	16,000	1,067	15	1,067		2,667	59
60	Building Improvements - Code Alert	2002	12,767	638	10	1,276	638	1,914	60
61	Building Improvements - Renovations- plumbing work	2002	4,712	157	15	314	157	471	61
62	Building Improvements - Renovations-plumbing and heating	2002	3,275	41	40	82	41	123	62
63	Building Improvements - painting, flooring, wallcoverings	2002	434,395	16,076	7	32,152	16,076	48,228	63
64	Building Improvements- walls, electrical, lighting	2002	431,434	3,103	40	6,206	3,103	9,309	64
65	Building Improvements- HVAC	2002	17,600	440	40	920	480	1,380	65
66	BI-Fire dampers	2003	62,407	2,080	15	2,080		2,080	66
67	BI-Door panels	2003	6,193	310	10	310		310	67
68	BI-Ceiling project	2003	21,725	272	40	272		272	68
69	BI-Alarm system	2003	35,502	888	20	888		888	69
70	TOTAL (lines 4 thru 69)		\$ 7,070,108	\$ 280,916		\$ 203,387	\$ (77,529)	\$ 2,487,382	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 South Nursing Home

# 0023242

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	\$ 7,070,108	\$ 280,916		\$ 203,387	\$ (77,529)	\$ 2,487,382		1
2	LI-Heated sidewalk	2003 32,012	1,067	15	1,067		1,067		2
3	LI-Sign	2003 784	39	10	39		39		3
4	BI-Thermostats, heaters, pump motor, valves	2003 10,902	272	20	272		272		4
5	BI-Gate	2003 3,050	76	20	76		76		5
6									6
7									7
8									8
9	Allocated from Home Office	600,223			15,532	15,532	23,725		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	TOTAL (lines 1 thru 33)	\$ 7,717,079	\$ 282,370		\$ 220,373	\$ (61,997)	\$ 2,512,561		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	\$ 1,685,164	\$ 168,218	\$ 162,844	\$ (5,374)	3-10 yrs	\$ 937,636	71
72	Current Year Purchases	80,928	4,964	4,964		5-15 yrs	4,964	72
73	Fully Depreciated Assets	1,508,733					1,508,733	73
74	Allocated from Home Office	476,204		51,345	51,345		207,780	74
75	TOTALS	\$ 3,751,029	\$ 173,182	\$ 219,153	\$ 45,971		\$ 2,659,113	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				\$	\$	\$	\$		\$	76
77	Allocated from Home Office			8,290		1,592	1,592		1,847	77
78										78
79										79
80	TOTALS			\$ 8,290	\$	\$ 1,592	\$ 1,592		\$ 1,847	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)	\$	11,507,703	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	455,552	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	441,118	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	(14,434)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	5,173,521	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*	
3	Original Building:			\$			3
4	Additions						4
5							5
6	Allocated from Home Office			3,097			6
7	<b>TOTAL</b>			\$ 3,097			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>/2004</u>	\$ _____
13.	<u>/2005</u>	\$ _____
14.	<u>/2006</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: N/A\*

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

15. Is Movable equipment rental included in building rental?  YES  NO  
 16. Rental Amount for movable equipment: \$ 0 Description: N/A

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18		<u>N/A</u>			18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	21

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

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

**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?          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>	<input type="checkbox"/> YES  <input checked="" type="checkbox"/> NO	<p>2. <b>CLASSROOM PORTION:</b></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. <b>CLINICAL PORTION:</b></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			Total
		1 Drop-outs	2 Completed	3 Contract	
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	<b>TOTALS</b>	\$	\$	\$	\$
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)	
<b>TOTAL TRAINED</b>	

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost						
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	L 10A, C 8	hrs	\$	3,468	\$ 347,652					3,468	\$ 347,652	1	
2	Licensed Speech and Language Development Therapist	L 10A, C 8	hrs		985	83,257					985	83,257	2	
3	Licensed Recreational Therapist		hrs										3	
4	Licensed Physical Therapist	L 10A, C 8	hrs		5,065	319,313			6,477		5,065	325,790	4	
5	Physician Care		visits										5	
6	Dental Care		visits										6	
7	Work Related Program		hrs										7	
8	Habilitation		hrs										8	
9	Pharmacy	L 39, C 2	# of prescripts						527,016			527,016	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10	
11	Academic Education		hrs										11	
12	Exceptional Care Program												12	
13	Other (specify):												13	
14	TOTAL			\$	9,518	\$ 750,222			\$ 533,493		9,518	\$ 1,283,715	14	

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

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 17

Facility Name &amp; ID Number Rest Haven South Nursing Home

# 0023242

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*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 10,808	\$ 10,808	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 276,100 )	1,393,841	1,393,841	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	9,000	9,000	7
8	Accounts Receivable (owners or related parties)	7,565,023	9,968,473	8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 8,978,672	\$ 11,382,122	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	31,305	31,305	13
14	Buildings, at Historical Cost	7,060,683	7,717,079	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,308,928	3,759,319	16
17	Accumulated Depreciation (book methods)	(5,535,005)	(5,173,521)	17
18	Deferred Charges		1,436	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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 4,865,911	\$ 6,335,618	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 13,844,583	\$ 17,717,740	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 1,120,999	\$ 1,120,999	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,321	4,321	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	148,532	148,532	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,187	10,187	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	2,918	2,918	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	See Schedule 17A	44,662	44,662	36
37	Due to Related Parties	4,621,605	4,621,605	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 5,953,224	\$ 5,953,224	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	9,321	9,321	39
40	Mortgage Payable			40
41	Bonds Payable		2,403,450	41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 9,321	\$ 2,412,771	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 5,962,545	\$ 8,365,995	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 7,882,038	\$ 9,351,745	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 13,844,583	\$ 17,717,740	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

Facility Name Rest Haven South Christian Nursing Home  
PROVIDER # 0023242  
Period Ending 12/31/2003

Schedule 17A

XV. BALANCE SHEET

C. Current Liabilities

Line 36, Other Current Liabilities (specify):

	<u>Operating</u>	<u>After Consolidation</u>
Resident Gifts	2,350	2,350
Dental W/H	1,614	1,614
TSA W/H Rhs	2,886	2,886
TDA W/H - South	35,316	35,316
TDA FICA W/H	1,393	1,393
Mony Life Ins. W/H	(512)	(512)
Levy	1,662	1,662
Credit Union W/H	(47)	(47)
<b>Total</b>	<b><u>44,662</u></b>	<b><u>44,662</u></b>

SEE ACCOUNTANTS' COMPILATION REPORT

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 8,252,966	1
2	Restatements (describe):		2
3	Prior period adjustment	(160,138)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 8,092,828	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(210,790)	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)	\$ (210,790)	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 7,882,038	24 *

Operating Entity Only

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Rest Haven South Nursing Home

# 0023242

Report Period Beginning: 01/01/03

Ending:

12/31/03

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

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 11,442,026	1
2	Discounts and Allowances for all Levels	(3,809,713)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 7,632,313	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,615,763	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,615,763	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	16,856	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	584,103	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	62,704	19
20	Radiology and X-Ray	20,028	20
21	Other Medical Services	343,769	21
22	Laundry	20,038	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 1,047,498	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a	See Schedule 19A	18,946	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 18,946	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 10,314,520	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,627,813	31
32	Health Care	5,095,081	32
33	General Administration	2,299,166	33
<b>B. Capital Expense</b>			
34	Ownership	620,081	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	789,546	35
36	Provider Participation Fee	93,623	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 10,525,310	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(210,790)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (210,790)	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.

**Rest Haven South Nursing Home**  
**Provider #: 0023242**  
**12/31/2003**

**Schedule 19A**

**XVII. INCOME STATEMENT**  
**Revenue - Line 28a**

E. Other Revenue (specify):	Amount
Other Income	4
Beauty/Barber	8,554
Day Care	213
Postage Revenue	12
Meals	8,267
Miscellaneous	1,896
	<u><u>18,946</u></u>

**See Accountants' Compilation Report**

Facility Name & ID Number Rest Haven South Nursing Home

# 0023242

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	2,065	2,088	\$ 62,783	\$ 30.07	1
2	Assistant Director of Nursing					2
3	Registered Nurses	31,987	33,982	821,757	24.18	3
4	Licensed Practical Nurses	28,287	29,633	591,266	19.95	4
5	Nurse Aides & Orderlies	145,765	154,981	1,887,683	12.18	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,103	2,240	40,482	18.07	9
10	Activity Assistants	5,597	6,096	75,519	12.39	10
11	Social Service Workers	6,358	7,097	95,293	13.43	11
12	Dietician	1,896	1,960	40,376	20.60	12
13	Food Service Supervisor	2,000	2,154	32,521	15.10	13
14	Head Cook	8,495	9,578	117,102	12.23	14
15	Cook Helpers/Assistants	19,649	20,659	192,624	9.32	15
16	Dishwashers					16
17	Maintenance Workers	14,083	15,313	190,554	12.44	17
18	Housekeepers	15,391	16,580	177,008	10.68	18
19	Laundry	10,294	10,870	113,841	10.47	19
20	Administrator	2,080	2,080	91,111	43.80	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	27,966	30,136	622,681	20.66	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	2,059	2,175	27,798	12.78	31
32	Other Health Care Case Manager	2,080	2,080	63,898	30.72	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	328,155	349,702	\$ 5,244,297 *	\$ 15.00	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	287	\$ 12,000	L 1, C 3	35
36	Medical Director	Monthly	12,000	L 9, C 3	36
37	Medical Records Consultant	Monthly	4,127	L 10, C 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,344	L 10, C 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	48	2,520	L 12, C 3	45
46	Other(specify) Chapel Ministry	44	1,380	L 12, C 3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	379	\$ 38,371		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	637	\$ 34,195	L 10, C 3	50
51	Licensed Practical Nurses	1,796	67,066	L 10, C 3	51
52	Nurse Aides	1,290	28,485	L 10, C 3	52
53	TOTAL (lines 50 - 52)	3,723	\$ 129,746		53

SEE ACCOUNTANTS' COMPILATION REPORT



**Rest Haven South Nursing Home**

**Provider #: 0023242**

**01/01/03 to 12/31/03**

**Schedule 21A**

**XIX. SUPPORT SCHEDULE**

**C. Professional Services**

<b>Total (agree to Schedule V, line 19, column 3)</b>	<b>53,705</b>
<b>Allocated from Management Company - Legal Fees</b>	<b>4,729</b>
<b>Allocated from Management Company - Other</b>	<b>10,629</b>
<b>Non-allowable Legal Fee</b>	<b>(1,525)</b>
<b>Total (agree to Schedule V, line 19, column 8)</b>	<b><u>67,538</u></b>

**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	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	Repair to Heater	Apr 2001	\$ 4,792		\$	\$ 799	\$ 1,597	\$ 1,597	\$ 799	\$	\$	\$
2	Repair to Fan Motors	June 2001	1,537			256	512	512	257			
3	Repair Fire Alarm	Oct 2001	2,280			380	760	760	380			
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS		\$ 8,609		\$	\$ 1,435	\$ 2,869	\$ 2,869	\$ 1,436	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Rest Haven South Nursing Home

# 0023242

Report Period Beginning: 01/01/03

Ending: 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. Life Services Network \$17,194
- (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 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 148,724 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. \$ 93,623  
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. \$ 8,267
- (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? Yes  
g. Does the facility transport residents to and from day training? N/A  
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 South Nursir 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	-542,470	equal to	-542,470	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	173,250	equal to	173,250	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	7,237	equal to	7,237	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	441,118	equal to	441,118	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	3,097	equal to	3,097	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	756,699	equal to	747,310	9,389	FAILED	Pg16 Z12+Z14...	N/A/B	1-4,40-43	8:2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	533,493	equal to	533,493	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	1,627,813	equal to	1,627,813	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	5,095,081	equal to	5,095,081	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Administration	2,299,166	equal to	2,299,166	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	620,081	equal to	620,081	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	789,546	equal to	789,546	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24++	N/A	38b41+43	4
Income Stat. Prov. Partic.	93,623	equal to	93,623	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	3,391,287	equal to	3,455,185	-63,898	FAILED	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	116,001	equal to	116,001	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	95,293	equal to	95,293	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	382,623	equal to	382,623	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	190,554	equal to	190,554	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	177,008	equal to	177,008	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	113,841	equal to	113,841	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	91,111	equal to	91,111	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	622,681	equal to	622,681	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	5,244,297	equal to	5,244,297	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	12,000	< or = to	12,000	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	12,000	< or = to	12,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	140,217	< or = to	140,217	0	O.K.	Pg20 X14..X16+	B. & C.	37b39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	0	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	2,520	< or = to	3,900	-1,380	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	91,111	equal to	91,111	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	430,308	equal to	430,308	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	53,705	equal to	53,705	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	960,416	equal to	960,416	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	31,920	equal to	31,920	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	21,750	equal to	21,750	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	93,623	equal to	93,623	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	< or = to	90,443	-90,443	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	7,478	equal to	7,478	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-139,190	equal to	-139,190	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6l Y4f	B.	14	8
Total loan balance	2,412,771	equal to	2,412,771	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	31,305	equal to	31,305	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	7,717,079	equal to	7,717,079	0	O.K.	Pg12 to 12l L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	3,759,319	equal to	3,759,319	0	O.K.	Pg13 O22+L13	C. & D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	5,173,521	equal to	5,173,521	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	7,882,038	equal to	7,882,038	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-210,790	equal to	-210,790	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	1,436	equal to	1,436	0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	13,844,583	equal to	13,844,583	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1



**Capital Gains Data**  
 Change year (Comment) \_\_\_\_\_  
 Facility Name \_\_\_\_\_  
 Real Estate Book Number Year \_\_\_\_\_

**YOU MUST CHOOSE THE CAPITAL GAIN THAT IS LIMITED TO THE COST BASIS BY THE COST BASIS TABLES**  
 COSTS INCLUDE ON PAGES 17 THROUGH 20 ONLY AT CELL C10  
 01/04/87 PM  
 000000

USA No. \_\_\_\_\_  
 IF SELECTED, have facilities been continuously owned from an unincorporated partnership since January 1, 1975 (or 1981 or across the first day of operation for buildings constructed since January 1, 1981)?  
 Yes or No (or R) \_\_\_\_\_  
 Yes or No Beginning \_\_\_\_\_  
 Cost Report No. \_\_\_\_\_  
 Loaned Beds \_\_\_\_\_  
 15% Total Patient Days \_\_\_\_\_  
 Advanced Bed Days \_\_\_\_\_  
 15% Total \_\_\_\_\_  
 15% Total \_\_\_\_\_  
 1989 Property Tax COST: \_\_\_\_\_  
 1989 Property Tax INSTEAD: \_\_\_\_\_  
 1989 (under lease) \_\_\_\_\_  
 FY 1989 Capital Gain \_\_\_\_\_

**CAPITAL CALCULATIONS**

- A. Determine the base year for your building from Work Table A  
 B. Determine the Building Specific historical cost per bed:  
 1. Which table, A or B, Column B?  
 2. Total historical costs from cost report Page 2, Column 3  
 3. Line 1, Column 3  
 4. Regular construction labor from Table 2  
 5. Building specific historical cost from Line 3, Line 4, round to even \$  
 C. Obtain the Uniform Building Value from Table 1  
 D. The value on line 5 will be calculated through a blending of the uniform building value from cost report and the building specific historical cost  
 1. Building specific historical cost from Line 5B  
 2. Uniform building value from Line 5C  
 3. Add Line 5B to 5C  
 4. Divide by 2 to obtain average  
 5. Round 50% of line 5  
 6. The lesser value of line 5  
 E. Divide the historical value from step D by 365 days to obtain a per diem historical value investment  
 F. Multiply the per diem historical value from step E by the applicable rate of return to obtain the building value base. (The rate of return is 1% for 1979 and later years and 8 1/2% for 1970 and other base years)  
 G. Add 25% to cover the acquisition, construction and working capital  
 H. Add Lines F & G to obtain the preliminary capital cost  
 I. Imputation of Capital Gains. (This step does not apply if the facility has been constructed or purchased after FY 81)  
 1. Enter the FY 81 acquisition  
 2. Subtract the FY 81 property tax rate  
 3. FY 81 rate without tax  
 4. Multiply Line G by 115%  
 J. Property Tax  
 Property taxes are taken from the Long Term Care Property Tax Department which was submitted to the Department of Public Aid during FY 83.  
 Imputation of Capital Gains is based upon the actual 1983 taxes for which the building forms were assessed. The formula used is a follow:  
 1. Property Tax Department Code Long Term Care Property Tax  
 2. Department Code Tax  
 3. County Property Tax Department Code  
 4. Equalize the County Code  
 5. Total Property Tax (Line J)  
 6. Equalize Property Tax Code  
 Capital Gains  
 The actual gains are the higher of the actual column (Page 4, Schedule B-B, Column 5, Line 10 or 10% of historical cost from page 3, Schedule A-A, Column 4, Line 7 - 9)  
 1. Total historical cost  
 2. Total Loaned Bed Days - 60  
 3. Total Property Tax (Line J)  
 4. Total (Line 10 or 10% of Line 2)  
 K. Total Capital Gains for FY 84  
 1. Enter the greater of the imputed value from Line I or the imputation value from Line J  
 2. Add Property Tax from Line J  
 3. Total capital gain from Line I & J

**Column**

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96

**WORK TABLE A**

Year	Column (A)-(D)	Line	Page	Year	Column (A)-(D)	Line	Page
1970	100	100	100	1970	100	100	100
1971	100	100	100	1971	100	100	100
1972	100	100	100	1972	100	100	100
1973	100	100	100	1973	100	100	100
1974	100	100	100	1974	100	100	100
1975	100	100	100	1975	100	100	100
1976	100	100	100	1976	100	100	100
1977	100	100	100	1977	100	100	100
1978	100	100	100	1978	100	100	100
1979	100	100	100	1979	100	100	100
1980	100	100	100	1980	100	100	100
1981	100	100	100	1981	100	100	100
1982	100	100	100	1982	100	100	100
1983	100	100	100	1983	100	100	100
1984	100	100	100	1984	100	100	100
1985	100	100	100	1985	100	100	100
1986	100	100	100	1986	100	100	100
1987	100	100	100	1987	100	100	100
1988	100	100	100	1988	100	100	100
1989	100	100	100	1989	100	100	100
1990	100	100	100	1990	100	100	100
1991	100	100	100	1991	100	100	100
1992	100	100	100	1992	100	100	100
1993	100	100	100	1993	100	100	100
1994	100	100	100	1994	100	100	100
1995	100	100	100	1995	100	100	100
1996	100	100	100	1996	100	100	100
1997	100	100	100	1997	100	100	100
1998	100	100	100	1998	100	100	100
1999	100	100	100	1999	100	100	100
2000	100	100	100	2000	100	100	100
2001	100	100	100	2001	100	100	100
2002	100	100	100	2002	100	100	100
2003	100	100	100	2003	100	100	100
2004	100	100	100	2004	100	100	100
2005	100	100	100	2005	100	100	100
2006	100	100	100	2006	100	100	100
2007	100	100	100	2007	100	100	100
2008	100	100	100	2008	100	100	100
2009	100	100	100	2009	100	100	100
2010	100	100	100	2010	100	100	100
2011	100	100	100	2011	100	100	100
2012	100	100	100	2012	100	100	100
2013	100	100	100	2013	100	100	100
2014	100	100	100	2014	100	100	100
2015	100	100	100	2015	100	100	100
2016	100	100	100	2016	100	100	100
2017	100	100	100	2017	100	100	100
2018	100	100	100	2018	100	100	100
2019	100	100	100	2019	100	100	100
2020	100	100	100	2020	100	100	100
2021	100	100	100	2021	100	100	100
2022	100	100	100	2022	100	100	100
2023	100	100	100	2023	100	100	100
2024	100	100	100	2024	100	100	100
2025	100	100	100	2025	100	100	100
2026	100	100	100	2026	100	100	100
2027	100	100	100	2027	100	100	100
2028	100	100	100	2028	100	100	100
2029	100	100	100	2029	100	100	100
2030	100	100	100	2030	100	100	100
2031	100	100	100	2031	100	100	100
2032	100	100	100	2032	100	100	100
2033	100	100	100	2033	100	100	100
2034	100	100	100	2034	100	100	100
2035	100	100	100	2035	100	100	100
2036	100	100	100	2036	100	100	100
2037	100	100	100	2037	100	100	100
2038	100	100	100	2038	100	100	100
2039	100	100	100	2039	100	100	100
2040	100	100	100	2040	100	100	100
2041	100	100	100	2041	100	100	100
2042	100	100	100	2042	100	100	100
2043	100	100	100	2043	100	100	100
2044	100	100	100	2044	100	100	100
2045	100	100	100	2045	100	100	100
2046	100	100	100	2046	100	100	100
2047	100	100	100	2047	100	100	100
2048	100	100	100	2048	100	100	100
2049	100	100	100	2049	100	100	100
2050	100	100	100	2050	100	100	100

**TABLE 1**

Table Uniform Building Value	Column (A)-(D)	Line	Page	Table Uniform Building Value	Column (A)-(D)	Line	Page
100	100	100	100	100	100	100	100
101	100	100	100	101	100	100	100
102	100	100	100	102	100	100	100
103	100	100	100	103	100	100	100
104	100	100	100	104	100	100	100
105	100	100	100	105	100	100	100
106	100	100	100	106	100	100	100
107	100	100	100	107	100	100	100
108	100	100	100	108	100	100	100
109	100	100	100	109	100	100	100
110	100	100	100	110	100	100	100
111	100	100	100	111	100	100	100
112	100	100	100	112	100	100	100
113	100	100	100	113	100	100	100
114	100	100	100	114	100	100	100
115	100	100	100	115	100	100	100
116	100	100	100	116	100	100	100
117	100	100	100	117	100	100	100
118	100	100	100	118	100	100	100
119	100	100	100	119	100	100	100
120	100	100	100	120	100	100	100
121	100	100	100	121	100	100	100
122	100	100	100	122	100	100	100
123	100	100	100	123	100	100	100
124	100	100	100	124	100	100	100
125	100	100	100	125	100	100	100
126	100	100	100	126	100	100	100
127	100	100	100	127	100	100	100
128	100	100	100	128	100	100	100
129	100	100	100	129	100	100	100
130	100	100	100	130	100	100	100
131	100	100	100	131	100	100	100
132	100	100	100	132	100	100	100
133	100	100	100	133	100	100	100
134	100	100	100	134	100	100	100
135	100	100	100	135	100	100	100
136	100	100	100	136	100	100	100
137	100	100	100	137	100	100	100
138	100	100	100	138	100	100	100
139	100	100	100	139	100	100	100
140	100	100	100	140	100	100	100
141	100	100	100	141	100	100	100
142	100	100	100	142	100	100	100
143	100	100	100	143	100	100	100
144	100	100	100	144	100	100	100
145	100	100	100	145	100	100	100
146	100	100	100	146	100	100	100
147	100	100	100	147	100	100	100
148	100	100	100	148	100	100	100
149	100	100	100	149	100	100	100
150	100	100	100	150	100	100	100
151	100	100	100	151			

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	382,623	55,773	12,000	450,396	0	450,396	0	450,396
2. Food Purchase	0	340,762	0	340,762	0	340,762	-6,166	334,596
3. Housekeeping	177,008	35,670	0	212,678	0	212,678	0	212,678
4. Laundry	113,841	19,063	0	132,904	0	132,904	-19,063	113,841
5. Heat and Other Utilities	0	0	154,848	154,848	0	154,848	11,083	165,931
6. Maintenance	190,554	0	145,671	336,225	0	336,225	-19,091	317,134
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	864,026	451,268	312,519	1,627,813	0	1,627,813	-33,237	1,594,576
9. Medical Director	0	0	12,000	12,000	0	12,000	0	12,000
10. Nursing & Medical Records	3,455,185	508,487	140,217	4,103,889	0	4,103,889	0	4,103,889
10a. Therapy	0	6,477	740,833	747,310	0	747,310	9,389	756,699
11. Activities	116,001	16,246	0	132,247	0	132,247	0	132,247
12. Social Services	95,293	442	3,900	99,635	0	99,635	0	99,635
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	3,666,479	531,652	896,950	5,095,081	0	5,095,081	9,389	5,104,470
17. Administrative	91,111	0	430,308	521,419	0	521,419	-430,308	91,111
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	53,705	53,705	0	53,705	13,833	67,538
20. Fees, Subscriptions & Promotion	0	0	27,880	27,880	0	27,880	4,040	31,920
21. Clerical & General Office	622,681	30,030	72,095	724,806	0	724,806	41,470	766,276
22. Employee Benefits & Payroll	0	0	869,973	869,973	0	869,973	90,443	960,416
23. Inservice Training & Education	0	0	0	0	0	0	786	786
24. Travel and Seminar	0	0	9,448	9,448	0	9,448	12,302	21,750
25. Other Admin. Staff Trans	0	0	0	0	0	0	0	0
26. Insurance-Prop.Liab.Malpractice	0	0	91,935	91,935	0	91,935	6,721	98,656
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	713,792	30,030	1,555,344	2,299,166	0	2,299,166	-260,713	2,038,453
29. Total General Administrative	5,244,297	1,012,950	2,764,813	9,022,060	0	9,022,060	-284,561	8,737,499
30. Depreciation	0	0	455,552	455,552	0	455,552	-14,434	441,118
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	164,529	164,529	0	164,529	8,721	173,250
33. Real Estate	0	0	0	0	0	0	7,237	7,237
34. Rent - Facility & Grounds	0	0	0	0	0	0	3,097	3,097
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	620,081	620,081	0	620,081	4,621	624,702
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	527,016	0	527,016	0	527,016	0	527,016
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	93,623	93,623	0	93,623	0	93,623
43. Other (specify):*	0	0	262,530	262,530	0	262,530	-262,530	0
44. Total Special Cost Ce	0	527,016	356,153	883,169	0	883,169	-262,530	620,639
45. Grand Total	5,244,297	1,539,966	3,741,047	10,525,310	0	10,525,310	-542,470	9,982,840

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	10,808	10,808
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Receivable	1,393,841	1,393,841
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	0	0
7. Other Prepaid Expenses	9,000	9,000
8. Accounts Receivable-Owner/Related Party	7,565,023	9,968,473
9. Other (specify):	0	0
10. Total current assets	8,978,672	11,382,122
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	31,305	31,305
14. Buildings, at Historical Cost	7,060,683	7,717,079
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	3,308,928	3,759,319
17. Accumulated Depreciation (book methods)	-5,535,005	-5,173,521
18. Deferred Charges	0	1,436
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	4,865,911	6,335,618
25. Total Assets	13,844,583	17,717,740
CURRENT LIABILITIES		
26. Accounts Payable	1,120,999	1,120,999
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	4,321	4,321
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	148,532	148,532
31. Accrued Taxes Payable	10,187	10,187
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	2,918	2,918
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	44,662	44,662
37. Other Current Liabilities (specify):	4,621,605	4,621,605
38. Total Current Liabilities	5,953,224	5,953,224
LONG TERM LIABILITES		
39. Long-Term Notes Payable	9,321	9,321
40. Mortgage Payable	0	0
41. Bonds Payable	0	2,403,450
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	9,321	2,412,771
46. Total Liabilities	5,962,545	8,365,995
47. Total Equity	7,882,038	9,351,745
48. Total Liabilities and Equity	13,844,583	17,717,740

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	11,442,026
2. Discounts and Allowances for all Levels	-3,809,713
Subtotal - Inpatient Care	7,632,313
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	1,615,763
7. Oxygen	0
Subtotal - Ancillary Revenue	1,615,763
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	16,856
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	584,103
18. Sale of Supplies to Non-Patients	0
19. Laboratory	62,704
20. Radiology and X-Ray	20,028
21. Other Medical Services	343,769
22. Laundry	20,038
Subtotal - Other Operating Revenue	1,047,498
24. Contributions	0
25. Interest and Other Investments Income	-1
Subtotal - Non-Operating Revenue	-1
27. Other Revenue (specify):	0
28. Other Revenue (specify):	18,947
Subtotal - Other Revenue	18,947
30. Total Revenue	10,314,520
31. General Services	1,627,813
32. Health Care	5,095,081
33. General Administration	2,299,166
34. Ownership	620,081
35. Special Cost Centers	789,546
35. Provider Participation Fee	93,623
37. Other	0
40. Total Expenses	10,525,310
41. Income Before Income Taxes	-210,790
42. Income Taxes	0
43. Net Income or Loss for the Year	-210,790

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- 23 Provider Participation fee is linked from page 4