



Facility Name & ID Number Rest Haven Central

# 0007534 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	5,674	5,520	20,340	31,534	8
9	SNF/PED					9
10	ICF	21,290	9,797		31,087	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,964	15,317	20,340	62,621	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.89%

D. How many bed-hold days during this year were paid by the Department? 0 (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 02/10/1960

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 20,340

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/07 Fiscal Year: 12/31/07

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

Facility Name & ID Number Rest Haven Central # 0007534 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	3,600	17,490	717,060	738,150	738,150		738,150			1
2	Food Purchase		577,476		577,476	577,476	15,629	593,105			2
3	Housekeeping	325,686	73,469		399,155	399,155		399,155			3
4	Laundry	57,749	19,919		77,668	77,668	(5,634)	72,034			4
5	Heat and Other Utilities			224,746	224,746	224,746	19,971	244,717			5
6	Maintenance	179,697		259,260	438,957	438,957	(72,391)	366,566			6
7	Other (specify):* <b>Mgmt Alloc of Benefit</b>						1,102	1,102			7
8	<b>TOTAL General Services</b>	566,732	688,354	1,201,066	2,456,152	2,456,152	(41,323)	2,414,829			8
	<b>B. Health Care and Programs</b>										
9	Medical Director			16,080	16,080	16,080		16,080			9
10	Nursing and Medical Records	4,013,145	574,955	694,821	5,282,921	5,282,921		5,282,921			10
10a	Therapy			1,364,529	1,364,529	1,364,529		1,364,529			10a
11	Activities	122,844	12,060		134,904	134,904		134,904			11
12	Social Services	177,108		3,013	180,121	180,121		180,121			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	4,313,097	587,015	2,078,443	6,978,555	6,978,555		6,978,555			16
	<b>C. General Administration</b>										
17	Administrative			1,307,892	1,307,892	1,307,892	(1,159,286)	148,606			17
18	Directors Fees										18
19	Professional Services			284,468	284,468	284,468	3,391	287,859			19
20	Dues, Fees, Subscriptions & Promotions			50,628	50,628	50,628	8,562	59,190			20
21	Clerical & General Office Expenses	409,515	65,212	89,654	564,381	564,381	498,831	1,063,212			21
22	Employee Benefits & Payroll Taxes			873,220	873,220	873,220		873,220			22
23	Inservice Training & Education										23
24	Travel and Seminar			4,293	4,293	4,293	12,657	16,950			24
25	Other Admin. Staff Transportation						6,184	6,184			25
26	Insurance-Prop.Liab.Malpractice			251,918	251,918	251,918	7,783	259,701			26
27	Other (specify):* <b>Mgmt Alloc of Benefit</b>						140,275	140,275			27
28	<b>TOTAL General Administration</b>	409,515	65,212	2,862,073	3,336,800	3,336,800	(481,603)	2,855,197			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	5,289,344	1,340,581	6,141,582	12,771,507	12,771,507	(522,926)	12,248,581			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.

Facility Name & ID Number Rest Haven Central

#0007534

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			461,405	461,405		461,405	5,712	467,117			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			256,729	256,729		256,729	25,328	282,057			32
33	Real Estate Taxes							11,843	11,843			33
34	Rent-Facility & Grounds							6,656	6,656			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			718,134	718,134		718,134	49,539	767,673			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		955,804		955,804		955,804		955,804			39
40	Barber and Beauty Shops	17,325			17,325		17,325		17,325			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			105,668	105,668		105,668		105,668			42
43	Other (specify):* <b>Non-allowable Cos</b>			647,121	647,121		647,121	(647,121)				43
44	<b>TOTAL Special Cost Centers</b>	17,325	955,804	752,789	1,725,918		1,725,918	(647,121)	1,078,797			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	5,306,669	2,296,385	7,612,505	15,215,559		15,215,559	(1,120,508)	14,095,051			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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,806)	2		4
5	Telephone, TV & Radio in Resident Rooms	(16,079)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(5,634)	4		8
9	Non-Straightline Depreciation	(58,181)	30		9
10	Interest and Other Investment Income	(1,527)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(82,489)	43		24
25	Fund Raising, Advertising and Promotional	(3,759)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(15,100)	43		28
29	Other-Attach Schedule See Pg. 5A	(558,246)	Vari		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (745,821)</b>		<b>\$</b>	<b>30</b>

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)	(374,687)	Vari	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (374,687)</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (1,120,508)</b>		<b>37</b>

\*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>			<b>\$</b>	<b>47</b>

BHF USE ONLY					
48	49	50	51	52	

SEE ACCOUNTANTS' COMPILATION REPORT

## Rest Haven Central

ID# 0007534

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Disallow non-allowable Lab Expense	\$ (43,909)	43	1
2	Disallow non-allowable X-Ray Expense	(68,524)	43	2
3				3
4	Disallow Interehab Physiatry	(106,371)	43	4
5	Disallow non-allowable residents welfare	(21,320)	43	5
6	Disallow non-allowable marketing expense	(301,392)	43	6
7	Disallow non-allowable accretion expense	(4,257)	43	7
8	Offset office income against related expense	(9,633)	21	8
9	To capitalize Repair Cost over \$2,500	(2,840)	6	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
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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	<b>Total</b>	(558,246)		49

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rest Haven Central# 0007534

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	20,435	0	0	0	0	0	0	0	0	0	20,435	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	19,971	0	0	0	0	0	0	0	0	0	19,971	5
6	Maintenance	(2,840)	(69,551)	0	0	0	0	0	0	0	0	0	(72,391)	6
7	Other (specify):*	0	1,102	0	0	0	0	0	0	0	0	0	1,102	7
8	<b>TOTAL General Services</b>	<b>(2,840)</b>	<b>(28,043)</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>(30,883)</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	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</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>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(1,159,286)	0	0	0	0	0	0	0	0	0	(1,159,286)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	3,391	0	0	0	0	0	0	0	0	0	3,391	19
20	Fees, Subscriptions & Promotions	0	8,562	0	0	0	0	0	0	0	0	0	8,562	20
21	Clerical & General Office Expenses	(9,633)	524,543	0	0	0	0	0	0	0	0	0	514,910	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	12,657	0	0	0	0	0	0	0	0	0	12,657	24
25	Other Admin. Staff Transportation	0	6,184	0	0	0	0	0	0	0	0	0	6,184	25
26	Insurance-Prop.Liab.Malpractice	0	0	7,783	0	0	0	0	0	0	0	0	7,783	26
27	Other (specify):*	0	0	140,275	0	0	0	0	0	0	0	0	140,275	27
28	<b>TOTAL General Administration</b>	<b>(9,633)</b>	<b>(603,949)</b>	<b>148,058</b>	<b>0</b>	<b>(465,524)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(12,473)</b>	<b>(631,992)</b>	<b>148,058</b>	<b>0</b>	<b>(496,407)</b>	<b>29</b>							

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rest Haven Central# 0007534

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(58,181)	0	63,893	0	0	0	0	0	0	0	0	5,712	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	26,855	0	0	0	0	0	0	0	0	26,855	32
33	Real Estate Taxes	0	0	11,843	0	0	0	0	0	0	0	0	11,843	33
34	Rent-Facility & Grounds	0	0	6,656	0	0	0	0	0	0	0	0	6,656	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>(58,181)</b>	<b>0</b>	<b>109,247</b>	<b>0</b>	<b>51,066</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):*	(560,873)	0	0	0	0	0	0	0	0	0	0	(560,873)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(560,873)</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>(560,873)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(631,527)</b>	<b>(631,992)</b>	<b>257,305</b>	<b>0</b>	<b>(1,006,214)</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
<u>Rest Haven Illiana Christian Convalescent Home</u>		<u>Rest Haven Central</u>	<u>Palos Heights</u>	<u>Holland Home</u>	<u>South Holland</u>	<u>Sheltered Care</u>
		<u>Rest Haven South</u>	<u>South Holland</u>	<u>Village Woods</u>	<u>Crete</u>	<u>Independent Ret.</u>
		<u>Rest Haven West</u>	<u>Downers Grove</u>	<u>Providence Mgmt. &amp; Development Co.</u>	<u>Tinley Park</u>	<u>Management Co.</u>
		<u>Haven Park</u>	<u>Zeeland, MI</u>	<u>Providence Home</u>		
				<u>Health Care</u>	<u>Tinley Park</u>	<u>Home Health</u>
				<u>Saratoga Grove</u>	<u>Downers Grove</u>	<u>Supportive Living</u>

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
1	V	2 <u>Food</u>	\$	<u>Rest Haven Illiana Christian Convalescent Home</u>	100.00%	\$ 20,435	\$	20,435	1
2	V	5 <u>Utilities</u>		<u>Rest Haven Illiana Christian Convalescent Home</u>	100.00%	19,971		19,971	2
3	V	6 <u>Maintenance - Salary</u>		<u>Rest Haven Illiana Christian Convalescent Home</u>	100.00%	4,713		4,713	3
4	V	6 <u>Maintenance - other</u>	84,932	<u>Rest Haven Illiana Christian Convalescent Home</u>	100.00%	10,668		(74,264)	4
5	V	7 <u>Mgmt. allocation of benefits</u>		<u>Rest Haven Illiana Christian Convalescent Home</u>	100.00%	1,102		1,102	5
6	V	17 <u>Administrative</u>	1,307,892	<u>Rest Haven Illiana Christian Convalescent Home</u>	100.00%	148,606		(1,159,286)	6
7	V	19 <u>Professional services - Legal</u>		<u>Rest Haven Illiana Christian Convalescent Home</u>	100.00%	3,391		3,391	7
8	V	20 <u>Dues, fees &amp; subscriptions</u>		<u>Rest Haven Illiana Christian Convalescent Home</u>	100.00%	8,562		8,562	8
9	V	21 <u>Clerical &amp; general - salary</u>		<u>Rest Haven Illiana Christian Convalescent Home</u>	100.00%	464,695		464,695	9
10	V	21 <u>Clerical &amp; general - other</u>		<u>Rest Haven Illiana Christian Convalescent Home</u>	100.00%	59,848		59,848	10
11	V	24 <u>Travel &amp; seminar</u>		<u>Rest Haven Illiana Christian Convalescent Home</u>	100.00%	12,657		12,657	11
12	V	25 <u>Other Admin. Staff transportation</u>		<u>Rest Haven Illiana Christian Convalescent Home</u>	100.00%	6,184		6,184	12
13	V								13
14	Total		\$ 1,392,824			\$ 760,832	\$ *	(631,992)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	26 Insurance - Prop., Liab & Malpracti	\$	Rest Haven Illiana Christian Convalescent Home	100.00%	\$ 7,783	\$	7,783	15
16	V	27 Mgmt. allocation of benefits		Rest Haven Illiana Christian Convalescent Home	100.00%	140,275		140,275	16
17	V	30 Depreciation		Rest Haven Illiana Christian Convalescent Home	100.00%	63,893		63,893	17
18	V	32 Interest		Rest Haven Illiana Christian Convalescent Home	100.00%	26,855		26,855	18
19	V	33 Real Estate Taxes		Rest Haven Illiana Christian Convalescent Home	100.00%	11,843		11,843	19
20	V	34 Rent - facility & grounds		Rest Haven Illiana Christian Convalescent Home	100.00%	6,656		6,656	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		\$			\$ 257,305	\$ *	257,305	39

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

Facility Name &amp; ID Number

Rest Haven Central

# 0007534

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6	N/A - Voluntary Board with no compensation. See Attached Schedule 7A										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:

01/01/2007

Ending:

12/31/2007

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	Food	Accumulated cost B	18	\$ 129,406		13,907,664	\$ 20,435	1
2	5	Utilities	Accumulated cost B	18	126,470		13,907,664	19,971	2
3	6	Maintenance - salary	Accumulated cost B	18	29,844	29,844	13,907,664	4,713	3
4	6	Maintenance	Accumulated cost B	18	67,558		13,907,664	10,668	4
5	7	Management allocation of employ	Accumulated cost B	18	6,979		13,907,664	1,102	5
6	17	Administrative	Direct cost	1	856,112	148,606	1	148,606	6
7	19	Professional services	Accumulated cost B	18	21,475		13,907,664	3,391	7
8	20	Dues, fees & subscriptions	Accumulated cost B	18	54,221		13,907,664	8,562	8
9	21	Clerical & general office expense	Accumulated cost B	18	2,942,747	2,942,747	13,907,664	464,695	9
10	21	Clerical & general office expense	Accumulated cost B	18	378,998		13,907,664	59,848	10
11	24	Travel & seminar	Accumulated cost B	18	80,152		13,907,664	12,657	11
12	25	Other admin. Staff transportation	Accumulated cost B	18	39,162		13,907,664	6,184	12
13	26	Insurance-prop., liab. & malpract	Accumulated cost B	18	49,285		13,907,664	7,783	13
14	27	Management allocation of employ	Accumulated cost B	18	888,311		13,907,664	140,275	14
15	30	Depreciation	Accumulated cost B	18	404,516		13,907,664	63,893	15
16	32	Interest expense	Accumulated cost B	18	170,066		13,907,664	26,855	16
17	33	Real estate taxes	Accumulated cost B	18	75,000		13,907,664	11,843	17
18	34	Rent - facility & grounds	Accumulated cost B	18	42,149		13,907,664	6,656	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 6,362,451	\$ 3,121,197		\$ 1,018,137	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Rest Haven Central

# 0007534

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	Tax Exempt Bonds		X	Mortgage & Additions	Varies	11/01/04	\$ 4,800,000	\$ 4,471,200	10/31/34	Variable	\$ 256,729	1						
2												2						
3												3						
4												4						
5												5						
<b>Working Capital</b>																		
6												6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>						\$ 4,800,000	\$ 4,471,200			\$ 256,729	9						
<b>B. Non-Facility Related*</b>																		
10									Disallow non-care interest		(1,527)	10						
11									Home office allocation		26,855	11						
12												12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 25,328	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 4,800,000	\$ 4,471,200			\$ 282,057	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ None                      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**

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

1. Real Estate Tax accrual used on 2006 report.		\$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2006	\$	N/A	2
3. Under or (over) accrual (line 2 minus line 1).		\$		3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	11,843	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	11,843	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2002	_____	8	
	2003	_____	9	
	2004	_____	10	
	2005	_____	11	
	2006	_____	12	
<b>Real estate taxes are allocated from a for-profit management entity.</b>				
<b>FOR BHF USE ONLY</b>				
	13	FROM R. E. TAX STATEMENT FOR 2006	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

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

SEE ACCOUNTANTS' COMPILATION REPORT

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2007 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, please call the Bureau of Health Finance at (217) 782-1630.

**2006 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 Cost**

Enter the tax index number and real estate tax assessed for 2006 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2006.

(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>19-09-01-203-007-0000</u>	<u>Home Office Building</u>	\$ <u>65,165.52</u>	\$ <u>11,843.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>65,165.52</u>	\$ <u>11,843.00</u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the original 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

**PLEASE NOTE:** Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Rest Haven Central

# 0007534

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 92,845 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 grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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	<u>Resident Care</u>	<u>441,662</u>	<u>1960</u>	<u>\$ 30,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>441,662</b>		<b>\$ 30,000</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Rest Haven Central

# 0007534

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	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		40			585,862	7
8			1975	147,301	3,683	40	3,683		121,518	8
<b>Improvement Type**</b>										
9	Improvements		1967	312,475	2,889	40	2,889		312,475	9
10	Improvements		1970	74,824	1,871	40	1,871		71,098	10
11	Improvements		1971	10,740	269	40	269		9,953	11
12	Improvements		1972	3,992	100	40	100		3,600	12
13	Improvements		1973	2,002	50	40	50		1,717	13
14	Improvements		1974	1,001	25	40	25		830	14
15	Improvements		1976	8,418	210	40	210		6,610	15
16	Improvements		1977	1,073	27	40	27		819	16
17	Improvements		1979	450	11	40	11		319	17
18	Improvements		1980	629	16	40	16		448	18
19	Improvements		1982	3,077	77	40	77		2,002	19
20	Improvements		1983	4,063	102	40	102		2,550	20
21	Improvements		1984	11,366	284	40	284		6,816	21
22	Improvements		1985	5,552	139	40	139		3,197	22
23	Improvements		1986	308,545	7,714	40	7,714		169,708	23
24	Improvements		1987	242,285	6,057	40	6,057		127,197	24
25	Improvements		1988	144,720	3,618	40	3,618		61,028	25
26	Improvements		1989	75,090	1,877	40	1,877		35,654	26
27	Improvements		1990	258,016	6,450	40	6,450		119,480	27
28	Improvements		1991	88,476	2,212	40	2,212		39,336	28
29	Improvements		1992	51,572	1,289	40	1,289		20,624	29
30	Improvements		1993	283,946	7,099	40	7,099		107,074	30
31	Improvements		1994	396,618	9,915	40	9,915		139,824	31
32	Improvements		1995	207,113	5,526	40	5,526		68,344	32
33	Improvements		1995	13,913	928	15	928		11,600	33
34	Parking Lot Expansion		1996	74,714	1,868	40	1,868		21,482	34
35	Wing C & D Renovations		1996	226,501	5,662	40	5,662		65,113	35
36			1996	279,308	6,982	40	6,982		80,293	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 Central

# 0007534

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

**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		\$ 3,565	37
38	Lighting System	1996	49,263	1,232	40	1,232		14,168	38
39	Architect Fees	1996	13,512	338	40	338		3,887	39
40	Alarm System	1996	4,704	314	15	314		3,611	40
41	Whirlpool Renovation	1996	11,914	794	15	794		9,131	41
42	Door	1996	656	44	15	44		506	42
43	Unit I & II Renovation	1996	22,981	574	40	574		6,601	43
44	Landscaping	1997	5,984	398	15	398		4,179	44
45	Unit I A & B remodel:Carpentry, elec. Plumb	1997	236,778	9,472	25	9,472		99,457	45
46	Unit I C & D remodel:Carpentry, elec. plumb.	1997	211,804	8,472	25	8,472		88,956	46
47	Unit I Whirlpool Renovation	1997	3,264	130	25	130		1,365	47
48	Unit II Whirlpool Renovation	1997	3,910	156	25	156		1,638	48
49	Plumbing	1997	1,595	64	25	64		672	49
50	Unit II Laundry Room Cabinets	1997	729	30	25	30		315	50
51	Chapel Roof	1997	8,750	350	25	350		3,675	51
52	Ramp Entrance	1997	32,456	1,298	25	1,298		13,629	52
53	Employee Patio	1997	3,975	159	25	159		1,670	53
54	Ramp Curbing	1997	1,396	56	25	56		588	54
55	Stairwell Doors	1997	1,833	74	25	74		777	55
56	Handicap Ramp	1997	12,166	486	25	486		5,103	56
57	Medical Supply Room Renovation	1997	20,773	830	25	830		8,715	57
58	Unit II A & B remodel:Carpentry, fire protection	1997	78,500	3,140	25	3,140		32,970	58
59	A & B Basement Remodeling	1997	2,331	94	25	94		987	59
60	Unit II Storage Room	1997	3,458	138	25	138		1,449	60
61	Unit I A & B remodel:Carpentry, elec., tile	1998	18,389	736	25	736		16,902	61
62	Unit II Handicap Ramp	1998	2,002	80	25	80		760	62
63	Unit II Storage Room	1998	8,807	352	25	352		3,344	63
64	Unit II A & B Bsmnt remodel:Carpty, elec, plumb.	1998	83,634	3,345	25	3,345		31,778	64
65	Unit I A & B remodel:Carpty,plmg, elec.	1998	19,906	796	25	796		7,562	65
66	Unit II A & B Bsmt remodel:Carpty & fire prot.	1998	10,676	427	25	427		4,057	66
67	Design Plan for Renovation	1998	706	28	25	28		266	67
68	Unit II A & B Bsmt remodel:Carpentry & fee	1998	2,314	93	25	93		883	68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 5,257,156	\$ 111,760		\$ 111,760		\$ 3,119,443	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Rest Haven Central

# 0007534

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

**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	<b>Totals from Page 12A, Carried Forward</b>		\$ 5,257,156	\$ 111,760		\$ 111,760	\$	\$ 3,119,443	1
2	Painting for Renovation	1998	3,873	154	25	154		1,463	2
3	Unit I A & B remodel:Carpty,& finishing	1998	20,171	806	25	806		7,657	3
4	Carpeting	1998	13,997		5			13,997	4
5	Unit I A & B remodel:Carpty, plmg, fire	1998	8,026	322	25	322		3,059	5
6	Unit II Patio /Alzheimer's Garden	1998	49,519	1,980	25	1,980		18,810	6
7	Hot Water Heater	1998	831	56	15	56		532	7
8	Roof	1998	991	100	10	100		950	8
9	A/C Circulator	1998	1,115	74	15	74		703	9
10	Chimney Vent	1998	519	20	25	20		190	10
11	Fascia	1998	789	32	25	32		304	11
12	Smoke Detectors	1998	1,081	72	15	72		684	12
13	Speed Bumps for Parking Lot	1998	781		5			781	13
14	Heating & Cooling System	1998	34,826	1,394	25	1,394		13,243	14
15	Nurses' Alarm System	1998	13,917	556	25	556		5,282	15
16	Piping	1998	682	28	25	28		266	16
17	Patio	1999	10,472	262	40	262		2,227	17
18	Carpeting	1999	6,283	628	10	628		5,338	18
19	Electrical Generator	1999	66,394	6,640	10	6,640		56,440	19
20	Wall Firestopping	1999	15,000	1,500	10	1,500		12,750	20
21	Interior design fee	1999	228	22	10	22		187	21
22	Electrical	1999	4,383	438	10	438		3,723	22
23	Wall Firestopping	1999	35,000	3,500	10	3,500		29,750	23
24	Switchboard	1999	5,696	570	10	570		4,845	24
25	Landscaping	1999	48,376	1,210	10	1,210		10,285	25
26	Parking Lot	1999	8,610	216	40	216		1,836	26
27	Air Conditioners	1999	80,030	8,004	40	8,004		68,034	27
28	Boiler Repairs	1999	9,060		10	906	906	7,702	28
29	Landscaping	2000	10,704	712	15	712		5,340	29
30	Patio Shelter	2000	5,150	256	20	256		1,920	30
31	Garden	2000	7,768	516	15	516		3,870	31
32	Benches	2000	958	94	10	94		705	32
33	Lobby remodel	2000	102,660	10,266	10	10,266		76,995	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 5,825,046	\$ 152,188		\$ 153,094	\$ 906	\$ 3,479,311	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Rest Haven Central

# 0007534

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

**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	<b>Totals from Page 12B, Carried Forward</b>		\$ 5,825,046	\$ 152,188		\$ 153,094	\$ 906	\$ 3,479,311	1
2	Dining Room Renovation	2000	6,269	416	15	416		3,120	2
3	Wing Renovation	2000	102,095	2,552	40	2,552		19,140	3
4	Boiler and Pump	2000	10,450	696	15	696		5,220	4
5	Ansul	2000	3,728	248	15	248		1,860	5
6	Generator	2000	8,629	430	20	430		3,225	6
7	Fire Alarm System	2000	10,135	252	40	252		1,890	7
8	Exhaust Fan	2000	2,780	184	15	184		1,380	8
9	Landscaping	2001	5,680	1,136	5	1,136		7,384	9
10	Lobby remodel	2001	41,806	1,045	40	1,045		6,793	10
11	A-Wing remodel	2001	51,393	1,285	40	1,285		8,353	11
12	Sinks	2001	5,165	344	15	344		2,236	12
13	Doors	2001	5,278	352	15	352		2,288	13
14	Ejector Pump	2001	9,674	645	15	645		4,193	14
15	Automatic door	2001	4,817	688	7	688		4,472	15
16	Dining Room Renovation	2001	3,076	439	7	439		2,854	16
17	Exam Room Decoration	2001	14,068	2,010	7	2,010		13,065	17
18	Sewage Pump	2002	718	48	15	48		264	18
19	Whirlpool renovation	2002	2,177	145	15	145		798	19
20	Roof renovation	2002	90,250	9,025	10	9,025		49,638	20
21	Code Alert	2002	3,164	316	10	316		1,738	21
22	Firestopping work	2002	3,108	78	40	78		429	22
23	Dining Room Renovation	2002	135,527	3,388	40	3,388		18,634	23
24	Cabinets	2002	4,928	704	7	704		3,872	24
25	Blinds	2002	1,045	149	7	149		820	25
26	File cabinets	2002	2,327	332	7	332		1,826	26
27	Furniture	2002	1,814	259	7	259		1,425	27
28	Dining Room Renovation	2003	17,358	2,480	7	2,480		11,025	28
29	Lights	2003	20,442	1,022	20	1,022		4,599	29
30	Roof renovation	2003	152,000	15,200	10	15,200		68,400	30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,544,947	\$ 198,056		\$ 198,962	\$ 906	\$ 3,730,252	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Rest Haven Central

# 0007534

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

**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	<b>Totals from Page 12C, Carried Forward</b>		\$ 6,544,947	\$ 198,056		\$ 198,962	\$ 906	\$ 3,730,252	1
2	Menu boards	2003	2,160	216	10	216		972	2
3	Carpeting	2003	5,957	851	7	851		3,830	3
4	Sliding doors	2003	2,100	210	10	210		945	4
5	Wander system	2003	21,630	1,082	20	1,082		5,379	5
6									6
7	Tile	2004	24,492	2,450	10	2,450		8,575	7
8	Door	2004	4,579	458	10	458		1,603	8
9	Basement restroom	2004	37,076	927	40	927		4,635	9
10	Lights/shades	2004	3,562	178	20	178		890	10
11	Awning	2004	10,790	1,079	10	1,079		3,777	11
12	Shades	2004	1,960	280	7	280		980	12
13	Exit ramps	2004	5,450	363	15	363		1,271	13
14									14
15	Fire Door	2005	5,637	564	10	564		1,410	15
16	Storm Sewer improvements	2005	42,800	2,140	20	2,140		5,350	16
17	Water Heaters	2005	8,808	588	15	588		1,470	17
18	Patio and Major Landscaping Improvements	2005	16,805	1,120	15	1,120		2,800	18
19	Lights	2005	16,708	836	20	836		2,090	19
20	Unit 1 basement Improvements	2005	4,165	208	20	208		520	20
21	Elevator	2005	28,163	1,408	20	1,408		3,520	21
22	Unit 1 basement windows	2005	7,750	194	40	194		485	22
23	Wallpaper	2005	8,185	1,170	7	1,170		2,925	23
24	Baseboards	2005	1,078	154	7	154		385	24
25	Dock flooring	2005	2,000	286	7	286		715	25
26	Window Coverings	2005	13,162	1,880	7	1,880		4,700	26
27	5 Ton 3 Phase Condensing Unit	2005	2,696	135	20	135		337	27
28	Carpeting	2005	1,254	63	20	63		157	28
29	Electric Door Unit	2005	1,087	54	20	54		135	29
30	PC Disposer	2005	2,699	135	20	135		337	30
31	Electric Door Unit	2005	1,529	76	20	76		190	31
32	Nurse Call System	2005	7,749	387	20	387		968	32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,836,978	\$ 217,549		\$ 218,454	\$ 906	\$ 3,791,603	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Rest Haven Central

# 0007534

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

**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	<b>Totals from Page 12D, Carried Forward</b>		\$ 6,836,978	\$ 217,549		\$ 218,454	\$ 905	\$ 3,791,603	1
2	Parking Lot Lights	2005	2,940	196	15	196		490	2
3	Patio & Drainage Improvements	2005	10,958	731	15	731		1,827	3
4	Driveway	2005	29,377	1,469	20	1,469		3,672	4
5	Elevator	2006	18,897	472	20	472		944	5
6	Security Alarm System	2006	115,751	5,788	10	5,788		11,576	6
7	Nurse Call System	2006	123,550	8,825	7	8,825		17,650	7
8	5 Ton Rooftop Water Heater/Circulation Pump	2006	10,954	365	15	365		730	8
9	Asbestos Retirement Obligation	2006	97,309	6,951	7	6,951		13,902	9
10	Whirlpool Tub	2006	41,350	1,378	15	1,378		2,756	10
11	CSH Heating Unit	2006	3,750	125	15	125		250	11
12	Dock Door	2006	3,959	99	20	99		198	12
13	Central Air Unit	2006	5,677	189	15	189		378	13
14	Auto Door Opener	2006	2,200	110	10	110		220	14
15	New Phone System	2007	99,033	4,952	10	4,952		4,952	15
16	Cabnets Remodel	2007	4,686	156	15	156		156	16
17	Front Desk Cabinets	2007	13,428	336	20	336		336	17
18	Sump Pump	2007	9,240	308	15	308		308	18
19	Fire Panel	2007	16,950	848	10	848		848	19
20	HVAC Fixed	2007	11,325	378	15	378		378	20
21	Door Installed	2007	3,320	111	15	111		111	21
22	Outlets	2007	10,620	2,655	2	2,655		2,655	22
23	Foyer Windows and Cabinets	2007	5,530	138	20	138		138	23
24	Boiler Repairs	2007	114,664	3,822	15	3,822		3,822	24
25	Dinning Windows & Kickplates	2007	4,894	122	20	122		122	25
26	Waterproof Basement	2007	3,300	110	15	110		110	26
27	Doors and Cabinets Installed	2007	6,572	164	20	164		164	27
28	HVAC C&D Wing Piping	2007	85,642	1,071	40	1,071		1,071	28
29	Audio Station, Shades, Control Box	2007	3,168	226	7	226		226	29
30	Sign Repair	2007	2,840		20	71	71	71	30
31									31
32	Allocated from Home Office	2007	662,035			23,452	23,452	92,911	32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 8,360,896	\$ 259,642		\$ 284,071	\$ 24,428	\$ 3,954,574	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	\$ 1,801,393	\$ 192,501	\$ 133,343	\$ (59,158)	Vari	\$ 1,400,881	71
72	Current Year Purchases	168,273	9,262	9,262		3-15 yrs	9,262	72
73	Fully Depreciated Assets	2,493,580					2,493,580	73
74	Allocation from Home Office	600,099		37,518	37,518		489,047	74
75	TOTALS	\$ 5,063,345	\$ 201,763	\$ 180,123	\$ (21,640)		\$ 4,392,770	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	Allocation from Home Office			\$ 6,181	\$	\$ 2,923	\$ 2,923		\$ 5,859	76
77										77
78										78
79										79
80	TOTALS			\$ 6,181	\$	\$ 2,923	\$ 2,923		\$ 5,859	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)	\$ 13,460,422	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 461,405	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 467,117	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 5,712	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 8,353,203	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	N/A				87
88					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.

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.  YES  NO

	1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:			\$			3
4	Additions						4
5							5
6	Allocated from Home Office			6,656			6
7	TOTAL			\$ 6,656			7

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

This amount was calculated by dividing the total amount to be amortized N/A  
by the length of the lease 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: 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			N/A		18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_  
Ending \_\_\_\_\_

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2008</u>	\$ _____
13.	<u>/2009</u>	\$ _____
14.	<u>/2010</u>	\$ _____

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

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

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

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

<p><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>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><b>2. 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 CNA _____</p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
  - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- 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, C3	hrs	\$	10,460	\$ 627,210	\$	10,460	\$ 627,210	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		3,193	191,590		3,193	191,590	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		9,095	545,729		9,095	545,729	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 prescrpts				955,804		955,804	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	<b>TOTAL</b>			\$	22,748	\$ 1,364,529	\$ 955,804	22,748	\$ 2,320,333	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Rest Haven Central

# 0007534

Report Period Beginning: 01/01/2007

Ending:

12/31/2007

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(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	\$ 10,960	\$ 10,960	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 240,553 )	2,832,149	2,832,149	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	13,809	13,809	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 2,856,918	\$ 2,856,918	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	30,000	30,000	13
14	Buildings, at Historical Cost	7,701,060	8,360,896	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,562,446	5,069,526	16
17	Accumulated Depreciation (book methods)	(9,467,504)	(8,353,203)	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	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 2,826,002	\$ 5,107,219	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 5,682,920	\$ 7,964,137	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 250,959	\$ 250,959	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,440	9,440	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	70,358	70,358	30
31	Accrued Taxes Payable (excluding real estate taxes)	38,529	38,529	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
	<b>Other Current Liabilities(specify):</b>			
36	<b>Due to/from Related Entities</b>	4,044,281	4,044,281	36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 4,413,567	\$ 4,413,567	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable		4,471,200	41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<b>Long-Term Liabilities</b>	131,430	131,430	43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 131,430	\$ 4,602,630	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 4,544,997	\$ 9,016,197	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 1,137,923	\$ (1,052,060)	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 5,682,920	\$ 7,964,137	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>994,417</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Prior Period Adjustment</b>	<b>1,440</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>995,857</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>142,066</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>142,066</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,137,923</b>	<b>24</b> *

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

SEE ACCOUNTANTS' COMPILATION REPORT

**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	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 14,523,417	1
2	Discounts and Allowances for all Levels	(3,933,886)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 10,589,531	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,475,511	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 3,475,511	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	8,008	13
14	Non-Patient Meals	4,806	14
15	Telephone, Television and Radio	16,079	15
16	Rental of Facility Space		16
17	Sale of Drugs	952,190	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	65,009	19
20	Radiology and X-Ray	54,608	20
21	Other Medical Services	176,616	21
22	Laundry	5,634	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 1,282,950	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	<u>Other Income</u>	6,224	28
28a	<u>Misc Charges</u>	3,409	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 9,633	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 15,357,625	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	2,456,152	31
32	Health Care	6,978,555	32
33	General Administration	3,336,800	33
	<b>B. Capital Expense</b>		
34	Ownership	718,134	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	1,620,250	35
36	Provider Participation Fee	105,668	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 15,215,559	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	142,066	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 142,066	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: 01/01/2007

Ending: 12/31/2007

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,184	1,192	\$ 45,436	\$ 38.12	1
2	Assistant Director of Nursing	744	752	21,118	28.08	2
3	Registered Nurses	33,431	34,846	991,005	28.44	3
4	Licensed Practical Nurses	34,847	36,213	811,285	22.40	4
5	CNAs & Orderlies	149,178	157,717	2,088,056	13.24	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,080	34,140	16.41	9
10	Activity Assistants	7,347	7,754	88,704	11.44	10
11	Social Service Workers	8,811	9,059	177,108	19.55	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	521	521	3,600	6.91	15
16	Dishwashers					16
17	Maintenance Workers	9,259	9,661	179,697	18.60	17
18	Housekeepers	27,233	28,946	325,686	11.25	18
19	Laundry	4,039	4,870	57,749	11.86	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,249	2,369	32,219	13.60	23
24	Clerical	25,059	26,983	377,296	13.98	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	3,789	4,116	56,245	13.66	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Beautician</u>	1,287	1,446	17,325	11.98	33
34	TOTAL (lines 1 - 33)	311,058	328,525	\$ 5,306,669 *	\$ 16.15	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			35	
36	Medical Director	Monthly	16,080	9(3)	36
37	Medical Records Consultant	Monthly	4,320	10(3)	37
38	Nurse Consultant	Monthly	6,945	10(3)	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Chapel Ministry</u>	Monthly	3,013	12(3)	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 30,358		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	6,813	\$ 424,743	10(3)	50
51	Licensed Practical Nurses	7,020	258,813	10(3)	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	13,833	\$ 683,556		53

SEE ACCOUNTANTS' COMPILATION REPORT

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Johanna R. Zandstra	Administrator	0	\$ 148,606	Workers' Compensation Insurance	\$ 128,383	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	47,580	Advertising: Employee Recruitment	11,401	
				FICA Taxes	393,515	Health Care Worker Background Check (Indicate # of checks performed <u>124</u> )	5,112	
				Employee Health Insurance	185,627	Patient Background Checks		
Amount paid out of home office, allocated in column 7				Employee Meals		Subscriptions	4,986	
				Illinois Municipal Retirement Fund (IMRF)*		JCAHO Exp	13,651	
				Employee Education	1,659	LSN Dues	9,432	
				Employee Welfare	46,208	Misc Dues	4,056	
				Employee Uniforms	1,887	Allocated from Home Office	8,562	
				Drug Testing	5,361	Less: Public Relations Expense	( )	
				TDA Expense	63,000	Non-allowable advertising	( )	
				Allocated from Home Office		Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 148,606					
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 873,220	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 59,190	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees - (eliminated in Col. 7)			\$ 1,307,892	N/A			Out-of-State Travel	\$
							In-State Travel	
							See Attached Schedule	1,397
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 1,307,892					
							Seminar Expense	
C. Professional Services							See Attached Schedule	2,896
Vendor/Payee	Type		Amount				Allocated from Home Office	12,657
Laner, Muchin, Dombrow, Becker, Levin & Tominberg, LTD	Legal Fees		94,661				Entertainment Expense	( )
McVey & Parsky, LLC	Legal Fees		1,521				(agree to Sch. V, line 24, col. 8)	
Myers, Miller & Krauskopf	Legal Fees		3,868				TOTAL	\$ 16,950
Sachnoff & Weaver, LTD	Legal Fees		35,767					
RSM McGladrey, Inc.	Accounting		5,855					
DaRT Chart Systems	Clinical Consulting		136,577					
KPMG LLP	Accounting		4,855					
Achieve Accreditations	Operations Consulting		1,364					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 284,468	TOTAL				

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

Rest Haven Illiana Christian

Provider #: 0007534

1/1/2007 to 12/31/2007

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3) 284,468

Allocated from Management Company:

Legal 3,391

Other 0

Total (agree to Schedule V, line 19, column 8) 287,859

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	Amount of Expense Amortized Per Year								
					FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012
1	N/A		\$		\$	\$	\$	\$ N/A	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven Central# 0007534Report Period Beginning: 01/01/2007Ending: 12/31/2007**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 - \$9,432
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 9 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 132,374 Line 10(2)
- (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 during this cost report period. \$ 105,668  
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.

**SEE ACCOUNTANTS' COMPILATION REPORT**

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 4,806
- (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 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