

Facility Name & ID Number Rest Haven South Nursing Home

0023242 Report Period Beginning: 01/01/07 Ending: 12/31/07

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 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 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	20,340	15,750	19,883	55,973	8	
9	SNF/PED					9	
10	ICF					10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	20,340	15,750	19,883	55,973	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.68%

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 Note: 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 N/A 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 19,883

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: 01/01/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number Rest Haven South Nursing Home # 0023242 Report Period Beginning: 01/01/07 Ending: 12/31/07

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
	A. General Services										
1	Dietary		32,261	622,932	655,193	655,193		655,193			1
2	Food Purchase		360,685		360,685	360,685	19,265	379,950			2
3	Housekeeping	195,901	51,891		247,792	247,792		247,792			3
4	Laundry	141,411	16,830		158,241	158,241	(4,650)	153,591			4
5	Heat and Other Utilities			224,528	224,528	224,528	18,913	243,441			5
6	Maintenance	209,461		256,985	466,446	466,446	(49,220)	417,226			6
7	Other (specify):* Mgmt Alloc-Benefits						1,044	1,044			7
8	TOTAL General Services	546,773	461,667	1,104,445	2,112,885	2,112,885	(14,648)	2,098,237			8
	B. Health Care and Programs										
9	Medical Director			12,563	12,563	12,563		12,563			9
10	Nursing and Medical Records	3,684,011	669,737	274,648	4,628,396	4,628,396		4,628,396			10
10a	Therapy		21,763	1,797,561	1,819,324	1,819,324		1,819,324			10a
11	Activities	255,060	14,595		269,655	269,655		269,655			11
12	Social Services	77,718	201	6,747	84,666	84,666		84,666			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,016,789	706,296	2,091,519	6,814,604	6,814,604		6,814,604			16
	C. General Administration										
17	Administrative			982,140	982,140	982,140	(877,924)	104,216			17
18	Directors Fees										18
19	Professional Services			156,315	156,315	156,315	3,212	159,527			19
20	Dues, Fees, Subscriptions & Promotions			28,091	28,091	28,091	8,109	36,200			20
21	Clerical & General Office Expenses	372,839	46,871	52,497	472,207	472,207	480,295	952,502			21
22	Employee Benefits & Payroll Taxes			841,610	841,610	841,610		841,610			22
23	Inservice Training & Education			5,786	5,786	5,786		5,786			23
24	Travel and Seminar			6,317	6,317	6,317	11,987	18,304			24
25	Other Admin. Staff Transportation						5,857	5,857			25
26	Insurance-Prop.Liab.Malpractice			226,226	226,226	226,226	7,371	233,597			26
27	Other (specify):* Mgmt Alloc-Benefits						132,846	132,846			27
28	TOTAL General Administration	372,839	46,871	2,298,982	2,718,692	2,718,692	(228,247)	2,490,445			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,936,401	1,214,834	5,494,946	11,646,181	11,646,181	(242,895)	11,403,286			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 South Nursing Home

#0023242

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	
	D. Ownership											
30	Depreciation			462,613	462,613		462,613	73,621	536,234			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			225,919	225,919		225,919	21,848	247,767			32
33	Real Estate Taxes							11,216	11,216			33
34	Rent-Facility & Grounds							6,303	6,303			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			688,532	688,532		688,532	112,988	801,520			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		850,564		850,564		850,564		850,564			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):* Non-allowable Cos			874,341	874,341		874,341	(874,341)				43
44	TOTAL Special Cost Centers		850,564	967,964	1,818,528		1,818,528	(874,341)	944,187			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,936,401	2,065,398	7,151,442	14,153,241		14,153,241	(1,004,248)	13,148,993			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	(87)	2		4
5	Telephone, TV & Radio in Resident Rooms	(16,468)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(4,650)	4		8
9	Non-Straightline Depreciation	13,111	30		9
10	Interest and Other Investment Income	(2,346)	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	(1,239)	32		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	(515,362)	43		24
25	Fund Raising, Advertising and Promotional	(3,555)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(19,692)	43		28
29	Other-Attach Schedule See Pg. 5A	(373,607)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (923,895)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(80,353)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (80,353)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,004,248)		37

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

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

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

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' COMPILATION REPORT

Rest Haven South Nursing Home

ID# 0023242

Report Period Beginning: 01/01/07

Ending: 12/31/07

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Disallow Lab	\$ (67,749)	43	1
2	Disallow Interehab Physiatry	(16,800)	43	2
3	Disallow residents welfare	(12,032)	43	3
4	Disallow Accretion expesne	(5,763)	43	4
5	Non-allowable Marketing	(233,388)	43	5
6	Capitalize Repair expense	(32,403)	6	6
7	Capitalize Maintence expense	(5,472)	6	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(373,607)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rest Haven South Nursing Home# 0023242

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	(87)	19,352	0	0	0	0	0	0	0	0	0	19,265	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(4,650)	0	0	0	0	0	0	0	0	0	0	(4,650)	4
5	Heat and Other Utilities	0	18,913	0	0	0	0	0	0	0	0	0	18,913	5
6	Maintenance	(37,875)	(11,345)	0	0	0	0	0	0	0	0	0	(49,220)	6
7	Other (specify):*	0	1,044	0	0	0	0	0	0	0	0	0	1,044	7
8	TOTAL General Services	(42,612)	27,964	0	0	0	0	0	0	0	0	0	(14,648)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(877,924)	0	0	0	0	0	0	0	0	0	(877,924)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	3,212	0	0	0	0	0	0	0	0	0	3,212	19
20	Fees, Subscriptions & Promotions	0	8,109	0	0	0	0	0	0	0	0	0	8,109	20
21	Clerical & General Office Expenses	(16,468)	496,763	0	0	0	0	0	0	0	0	0	480,295	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	11,987	0	0	0	0	0	0	0	0	0	11,987	24
25	Other Admin. Staff Transportation	0	5,857	0	0	0	0	0	0	0	0	0	5,857	25
26	Insurance-Prop.Liab.Malpractice	0	7,371	0	0	0	0	0	0	0	0	0	7,371	26
27	Other (specify):*	0	0	132,846	0	0	0	0	0	0	0	0	132,846	27
28	TOTAL General Administration	(16,468)	(344,625)	132,846	0	(228,247)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(59,080)	(316,661)	132,846	0	(242,895)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rest Haven South Nursing Home# 0023242

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	13,111	0	60,510	0	0	0	0	0	0	0	0	73,621	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,585)	0	25,433	0	0	0	0	0	0	0	0	21,848	32
33	Real Estate Taxes	0	0	11,216	0	0	0	0	0	0	0	0	11,216	33
34	Rent-Facility & Grounds	0	0	6,303	0	0	0	0	0	0	0	0	6,303	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	9,526	0	103,462	0	112,988	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(874,341)	0	0	0	0	0	0	0	0	0	0	(874,341)	43
44	TOTAL Special Cost Centers	(874,341)	0	0	0	0	0	0	0	0	0	0	(874,341)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(923,895)	(316,661)	236,308	0	(1,004,248)	45							

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
<u>Rest Haven Illiana Christian</u>		<u>Rest Haven Central</u>	<u>Palos Heights</u>	<u>Holland Home</u>	<u>South Holland</u>	<u>Sheltered Care</u>
<u>Convalescent Home</u>	<u>100</u>	<u>Rest Haven West</u>	<u>Downers Grove</u>	<u>Village Woods</u>	<u>Crete</u>	<u>Independent Ret.</u>
		<u>Haven Park</u>	<u>Zeeland,MI</u>	<u>Providence Mgmt. & Development Co.</u>	<u>Tinley Park</u>	<u>Management Co.</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 Food	\$	<u>Rest Haven Illiana Christian</u>	100.00%	\$ 19,352	\$ 19,352	1
2	V	5 Utilities		<u>Rest Haven Illiana Christian</u>	100.00%	18,913	18,913	2
3	V	6 Maintenance - salary		<u>Rest Haven Illiana Christian</u>	100.00%	4,463	4,463	3
4	V	6 Maintenance	25,911	<u>Rest Haven Illiana Christian</u>	100.00%	10,103	(15,808)	4
5	V	7 Management allocation of employee benefits		<u>Rest Haven Illiana Christian</u>	100.00%	1,044	1,044	5
6	V	17 Administrative	982,140	<u>Rest Haven Illiana Christian</u>	100.00%	104,216	(877,924)	6
7	V	19 Professional services		<u>Rest Haven Illiana Christian</u>	100.00%	3,212	3,212	7
8	V	20 Dues, fees & subscriptions		<u>Rest Haven Illiana Christian</u>	100.00%	8,109	8,109	8
9	V	21 Clerical & general office expense - salary		<u>Rest Haven Illiana Christian</u>	100.00%	440,084	440,084	9
10	V	21 Clerical & general office expense		<u>Rest Haven Illiana Christian</u>	100.00%	56,679	56,679	10
11	V	24 Travel & seminar		<u>Rest Haven Illiana Christian</u>	100.00%	11,987	11,987	11
12	V	25 Other admin. Staff transportation		<u>Rest Haven Illiana Christian</u>	100.00%	5,857	5,857	12
13	V	26 Insurance-prop., liab. & malpractice		<u>Rest Haven Illiana Christian</u>	100.00%	7,371	7,371	13
14	Total		\$ 1,008,051			\$ 691,390	\$ * (316,661)	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	27 Management allocation of employee ben	\$	Rest Haven Illiana Christian	100.00%	\$ 132,846	\$	132,846	15
16	V	30 Depreciation		Rest Haven Illiana Christian	100.00%	60,510		60,510	16
17	V	32 Interest expense		Rest Haven Illiana Christian	100.00%	25,433		25,433	17
18	V	33 Real estate taxes		Rest Haven Illiana Christian	100.00%	11,216		11,216	18
19	V	34 Rent - facility & grounds		Rest Haven Illiana Christian	100.00%	6,303		6,303	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		\$			\$ 236,308	\$ *	236,308	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: 01/01/07 Ending: 12/31/07

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 South Nursing Home

0023242

Report Period Beginning:

01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Rest Haven Illiana Christian Conv. Home
 Street Address 18601 North Creek Drive
 City / State / Zip Code Tinsley 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		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	2	Food	Accumulated Cost B	18	\$ 129,406	\$	13,171,099	\$ 19,352	1
2	5	Utilities	Accumulated Cost B	18	126,470		13,171,099	18,913	2
3	6	Maintenance - salary	Accumulated Cost B	18	29,844	29,844	13,171,099	4,463	3
4	6	Maintenance	Accumulated Cost B	18	67,558		13,171,099	10,103	4
5	7	Management allocation of employ	Accumulated Cost B	18	6,979		13,171,099	1,044	5
6	17	Administrative	Direct Cost A	1	856,112	104,216	1	104,216	6
7	19	Professional services	Accumulated Cost B	18	21,475		13,171,099	3,212	7
8	20	Dues, fees & subscriptions	Accumulated Cost B	18	54,221		13,171,099	8,109	8
9	21	Clerical & general office expense	Accumulated Cost B	18	2,942,747	2,942,747	13,171,099	440,084	9
10	21	Clerical & general office expense	Accumulated Cost B	18	378,998		13,171,099	56,679	10
11	24	Travel & seminar	Accumulated Cost B	18	80,152		13,171,099	11,987	11
12	25	Other admin. Staff transportation	Accumulated Cost B	18	39,162		13,171,099	5,857	12
13	26	Insurance-prop., liab. & malpract	Accumulated Cost B	18	49,285		13,171,099	7,371	13
14	27	Management allocation of employee	Accumulated Cost B	18	888,311		13,171,099	132,846	14
15	30	Depreciation	Accumulated Cost B	18	404,615		13,171,099	60,510	15
16	32	Interest expense	Accumulated Cost B	18	170,066		13,171,099	25,433	16
17	33	Real estate taxes	Accumulated Cost B	18	75,000		13,171,099	11,216	17
18	34	Rent - facility & grounds	Accumulated Cost B	18	42,149		13,171,099	6,303	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 6,362,550	\$ 3,076,807		\$ 927,698	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven South Nursing Home # 0023242 Report Period Beginning: 01/01/07 Ending: 12/31/07

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Individual Notes		X	Building Improvements	Varies	Varies	\$ 70,321	\$ 25,321	Varies	Varies	\$ 1,281	1								
2	Tax Exempt Bonds		X	Building	Varies	11/01/04	4,200,000	3,912,300	10/31/2034	Varies	224,638	2								
3												3								
4												4								
5												5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 4,270,321	\$ 3,937,621			\$ 225,919	9								
B. Non-Facility Related*																				
10							Offset interest income				(2,346)	10								
11							Less Interest swap expense				(1,239)	11								
12							Allocated from Home Office				25,433	12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ 21,848	14								
15	TOTALS (line 9+line14)						\$ 4,270,321	\$ 3,937,621			\$ 247,767	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
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.	Allocated from Home Office		11,216
TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	11,216
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2002	8	
	2003	9	
	2004	10	
	2005	11	
	2006	12	
Real estate taxes are allocated from a for-profit management entity.			
FOR BHF USE ONLY			
	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

Facility Name & ID Number Rest Haven South Nursing Home

0023242

Report Period Beginning:

01/01/07

Ending:

12/31/07

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? [X] (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? [X] (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).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [] YES [X] 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:

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and an unlabeled column. Row 1: Facility, Not Available, 1976, \$ 31,305, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, (blank), (blank), \$ 31,305, 3.

SEE ACCOUNTANTS' COMPILATION REPORT

Rest Haven South Christian Nursing Home

Provider #: 0023242

1/1/2007 to 12/31/2007

Schedule 11A

Disclosure:

Transferred building to a single member LLC, Christian Living Campus, NFP.
All intercompany income and expenses have been eliminated.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven South Nursing Home

0023242

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	171	1977	1977	\$ 2,657,266	\$ 66,432	40	\$ 66,432	\$	\$ 1,990,271	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Landscaping Improvements		1977	19,723		20			19,723	9
10	Building Improvements		1978	7,401		40	185	185	3,559	10
11	Land Improvements		1981	2,535		20			2,535	11
12	Building Improvements		1982	8,179		40	204	204	5,125	12
13	Building Improvements		1983	4,035		40	101	101	2,434	13
14	Land Improvements		1984	7,625		20			7,625	14
15	Building Improvements		1985	2,029		40	51	51	1,127	15
16	Building Improvements		1986	49,092		40	1,227	1,227	25,998	16
17	Building Improvements		1987	48,670		40	1,217	1,217	24,594	17
18	Land Improvements		1987	4,898	182	20	182		4,898	18
19	Building Improvements		1988	21,602	1,428	40	540	(888)	10,388	19
20	Land Improvements		1988	1,600	80	20	80		1,542	20
21	Building Improvements		1898	561,415	14,035	40	14,035		256,300	21
22	Land Improvements		1898	9,437	472	20	472		8,634	22
23	Building Improvements		1990	98,412	6,561	40	2,460	(4,101)	42,528	23
24	Building Improvements		1991	74,357	4,957	40	1,859	(3,098)	30,323	24
25	Building Improvements		1992	168,370	4,209	40	4,209		64,553	25
26	Land Improvements		1992	13,785	689	20	689		10,585	26
27	Building Improvements		1994	24,717	1,648	40	618	(1,030)	8,273	27
28	Building Improvements		1995	52,042	3,469	40	1,301	(2,168)	16,262	28
29	Land Improvements		1995	10,722	536	20	536		6,700	29
30	Landscaping		1996	20,214	1,347	20	1,010	(337)	11,313	30
31	Building Redecorating		1996	15,578	1,039	40	390	(649)	4,625	31
32	Building Improvement - Ceiling		1996	25,000	1,667	40	625	(1,042)	6,927	32
33	Building Improvements - HVAC		1996	5,000		40	125	125	1,385	33
34	Landscaping		1997	27,690	1,846	20	1,349	(497)	14,340	34
35	Building Resident Room Redecorating		1997	64,348	4,290	40	1,609	(2,681)	16,701	35
36	Building - Ceiling & Lighting		1997	62,447	3,663	40	1,561		16,818	36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven South Nursing Home

0023242

Report Period Beginning:

01/01/07

Ending:

12/31/07

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)	\$ 1,213	37
38	Building - HVAC	1997	43,720	2,915	40	1,093	(1,822)	11,750	38
39	Building Improvement Resident Rooms in Gilead Area	1997	44,208	2,947	40	1,105	(1,842)	11,112	39
40	Building - Elevator Repair	1997	12,780	852	40	320	(532)	3,433	40
41	Building - Beauty Shop Renovation	1997	1,800	120	40	45	(75)	458	41
42	Land Improvement - Parking Lot	1998	46,302	2,315	20	2,316	1	22,002	42
43	Building Improvement Resident Rooms in Gilead Area	1998	34,374	2,338	40	859	(1,479)	8,161	43
44	Building - HVAC	1998	40,850	2,723	40	1,021	(1,702)	9,700	44
45	Building Rehab. Area	1998	68,738	4,455	40	1,718	(2,737)	16,321	45
46	Building - Kitchen Fan	1999	1,400	93	40	35	(58)	298	46
47	Building Therapy Room Renovation	1999	2,083	139	40	52	(87)	442	47
48	Building Improvement HVAC	2000	801,268	54,236	40	20,032	(34,204)	160,256	48
49	Building Improvement Social Service Office	2000	1,683	123	7	123		1,683	49
50	Land Improvement - Lighting	2000	30,000	2,000	15	2,000		15,000	50
51	Land Improvement - Fencing	2000	8,071	538	15	538		4,035	51
52	Building Improvement HVAC	2000	663,243	43,915	40	16,581	(27,334)	124,358	52
53	Building - Garage	2000	3,820	382	20	191	(191)	1,433	53
54	Building Improvement - Pipe Enclosure	2000	82,716	11,817	40	2,068	(9,749)	15,510	54
55	Building Improvement - Tile in Kitchen place into service 2001	2001	6,800	974	7	974		6,800	55
56	Land Improvement - Light Poles	2001	1,878	125	15	125		812	56
57	Building Improvements - HVAC	2001	19,808	780	40	495	(285)	3,218	57
58	Building Improvements - Kitchen Floor	2001	35,884	2,392	15	2,392		15,548	58
59	Building Improvements - Fire Protection System	2001	16,000	1,067	15	1,067		6,935	59
60	Building Improvements - Code Alert	2002	12,767	1,276	10	1,276		7,018	60
61	Building Improvements - Renovations- plumbing work	2002	4,712	314	15	314		1,727	61
62	Building Improvements - Renovations-plumbing and heating	2002	3,275	82	40	82		451	62
63	Building Improvements - painting, flooring, wallcoverings	2002	434,395	32,152	7	32,152		176,836	63
64	Building Improvements- walls, electrical,lighting	2002	431,434	6,206	40	6,206		34,133	64
65	Building Improvements- HVAC	2002	17,600	920	40	920		5,060	65
66	BI-Fire dampers	2003	62,407	4,161	15	4,161		18,724	66
67	BI-Door panels	2003	6,193	620	10	620		2,790	67
68	BI-Ceiling project	2003	21,725	543	40	543		2,444	68
69	BI-Alarm system	2003	35,502	1,775	20	1,775		7,988	69
70	TOTAL (lines 4 thru 69)		\$ 7,070,108	\$ 304,485		\$ 206,378	\$ (96,005)	\$ 3,313,735	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:

01/01/07

Ending:

12/31/07

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	\$ 304,485		\$ 206,378	\$ (98,107)	\$ 3,313,735	1
2	LI-Heated sidewalk	2003	32,012	2,134	15	2,134		9,603	2
3	LI-Sign	2003	784	78	10	78		351	3
4	BI-Thermostats, heaters, pump motor, valves	2003	10,902	545	20	545		2,452	4
5	BI-Gate	2003	3,050	153	20	153		688	5
6	BI-Dental office	2004	15,500	388	40	388		1,358	6
7	BI-Alarm system	2004	2,860	409	7	409		1,431	7
8	BI-Fire protection system	2004	3,500	350	10	350		1,225	8
9	BI-Activity room	2004	967	138	7	138		483	9
10	BI-Fire protection cabinet	2004	2,850	407	7	407		1,425	10
11									11
12	BI - Generator	2005	92,610	4,630	20	4,630		11,575	12
13	BI - HVAC	2005	6,932	346	20	346		865	13
14	BI - Sprinklers	2005	3,815	190	20	190		475	14
15	BI - Generator	2005	3,668	184	20	184		460	15
16	BI - Outside Lights	2005	1,328	66	20	66		165	16
17	BI - Drywall	2005	880	44	20	44		110	17
18	BI - Elevator	2005	2,007	100	20	100		250	18
19	BI - Doors	2005	9,220	462	20	462		1,155	19
20	BI - Plumbing	2005	3,276	164	20	164		410	20
21	BI - Fire Alarm System	2005	6,975	348	20	348		870	21
22	BI - Master Station (Nurse Call)	2005	1,705	86	20	86		215	22
23	BI - Conveyor Warewashers	2005	1,772	88	20	88		220	23
24									24
25	BI - HVAC	2006	8,729	436	20	436		654	25
26	BI - Fire Doors	2006	4,635	232	20	232		348	26
27	BI - Elevator Repair	2006	4,031	202	20	202		303	27
28	LI - Landscaping	2006	3,189	160	20	160		240	28
29									29
30	SO-Asbestos Retirement Obligation	2006	118,956		20	5,948	5,948	8,922	30
31	South-roof replacmt.	2006	76,485	7,649	10	7,649		11,473	31
32	Roof replace middle	2006	34,668		10	3,467	3,467	5,200	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,527,414	\$ 324,474		\$ 235,782	\$ (88,692)	\$ 3,376,661	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rest Haven South Nursing Home

0023242

Report Period Beginning:

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 7,527,414	\$ 324,474		\$ 235,782	\$ (88,692)	\$ 3,376,661	1
2	Boiler repair	2006	1,672		15	111	111	167	2
3	2 Condensers	2006	15,590		15	1,039	1,039	1,559	3
4	HVAC Controls	2006	8,150		15	543	543	815	4
5	Whirlpool flush	2006	395		15	26	26	39	5
6	Grease trap	2006	7,120		15	474	474	711	6
7	Elevator rebuild	2006	61,940		20	3,098	3,098	4,647	7
8	Whirlpool remodel	2006	51,113		20	2,556	2,556	3,834	8
9	Analog Msg Waiting Card	2006	6,871		7	982	982	1,473	9
10	Phone Cables	2006	17,500		7	2,500	2,500	3,750	10
11	Landscape	2006	1,950		10	196	196	294	11
12	Driveway Lights	2006	18,400		15	1,226	1,226	1,839	12
13									13
14	Sign painting & Maint	2007	5,472		5	547	547	547	14
15	Remove 377 sq ft of asphalt & construct 2 speed bumps	2007	2,975		8	186	186	186	15
16	Canopy repairs	2007	3,285		15	110	110	110	16
17	Phone System	2007	91,454	4,616	10	4,616		4,616	17
18	Roofing	2007	60,268	3,013	10	3,013		3,013	18
19	Sewer repairs	2007	28,997	523	15	967	444	967	19
20	Driveway Land Improvements	2007	6,900	230	15	230		230	20
21	Repair, test & Certify 2 failed backflow systems	2007	2,600		5	260		260	21
22	Elevator repairs	2007	2,899		10	95	95	95	22
23	Fire alarm repairs	2007	4,470		10	224	224	224	23
24									24
25									25
26									26
27	Allocation from Home Office	2007	626,973			22,210	22,210	87,990	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,554,408	\$ 332,856		\$ 280,991	\$ (52,125)	\$ 3,494,027	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rest Haven South Nursing Home

0023242

Report Period Beginning:

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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	\$ 2,044,084	\$ 123,508	\$ 210,694	\$ 87,186	3-15	\$ 1,529,245	71
72	Current Year Purchases	113,263	6,249	6,249		10	6,249	72
73	Fully Depreciated Assets	1,508,733					1,508,733	73
74	Allocation from Home Office	568,317		35,532	35,532		463,146	74
75	TOTALS	\$ 4,234,397	\$ 129,757	\$ 252,475	\$ 122,718		\$ 3,507,373	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	Allocation from Home Office			5,853		2,768	2,768		5,549	77
78										78
79										79
80	TOTALS			\$ 5,853	\$	\$ 2,768	\$ 2,768		\$ 5,549	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)	\$ 12,825,963	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 462,613	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 536,234	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 73,621	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 7,006,949	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: See attached Schedule 11A

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		Allocation from Home Office			6,303			6
7	TOTAL				\$ 6,303			7

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

This amount was calculated by dividing the total amount to be amortized by the length of the lease 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			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>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <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>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	11,584	\$ 695,016	\$	11,584	\$ 695,016	1	
2	Licensed Speech and Language Development Therapist	10(A)	hrs		2,358	141,466		2,358	141,466	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	10A(2,3)	hrs		16,018	961,079	21,763	16,018	982,842	4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy	39(2)	# of prescripts				850,564		850,564	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			\$	29,960	\$ 1,797,561	\$ 872,327	29,960	\$ 2,669,888	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 & ID Number Rest Haven South Nursing Home

0023242

Report Period Beginning: 01/01/07

Ending:

12/31/07

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/07

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 850	\$ 850	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 885,215)	1,963,779	1,963,779	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	52,611	52,611	7
8	Accounts Receivable (owners or related parties)	1,101,276	5,013,576	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,118,516	\$ 7,030,816	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	31,305	31,305	13
14	Buildings, at Historical Cost	7,990,654	8,554,408	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,442,776	4,240,250	16
17	Accumulated Depreciation (book methods)	(7,417,222)	(7,006,949)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,047,513	\$ 5,819,014	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,166,029	\$ 12,849,830	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 86,665	\$ 86,665	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	20,872	20,872	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	81,382	81,382	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,924	5,924	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	3,016	3,016	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	TDA Match - South	38,168	38,168	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 236,027	\$ 236,027	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	25,321	25,321	39
40	Mortgage Payable			40
41	Bonds Payable		3,912,300	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Long-Term Liabilities	197,868	197,868	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 223,189	\$ 4,135,489	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 459,216	\$ 4,371,516	46
47	TOTAL EQUITY(page 18, line 24)	\$ 6,706,813	\$ 8,478,314	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,166,029	\$ 12,849,830	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 6,355,240	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 6,355,240	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	351,573	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)	\$ 351,573	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 6,706,813	24 *

* 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	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 15,737,610	1
2	Discounts and Allowances for all Levels	(2,911,253)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,826,357	3
	B. Ancillary Revenue		
4	Day Care	152	4
5	Other Care for Outpatients		5
6	Therapy	191,080	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 191,232	8
	C. Other Operating Revenue		
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	20,424	13
14	Non-Patient Meals	87	14
15	Telephone, Television and Radio	16,468	15
16	Rental of Facility Space		16
17	Sale of Drugs	855,384	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	59,621	19
20	Radiology and X-Ray	53,891	20
21	Other Medical Services	424,156	21
22	Laundry	4,650	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,434,681	23
	D. Non-Operating Revenue		
24	Contributions	44,900	24
25	Interest and Other Investment Income***	2,346	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 47,246	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Charges</u>	5,298	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 5,298	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,504,814	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,112,885	31
32	Health Care	6,814,604	32
33	General Administration	2,718,692	33
	B. Capital Expense		
34	Ownership	688,532	34
	C. Ancillary Expense		
35	Special Cost Centers	1,724,905	35
36	Provider Participation Fee	93,623	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,153,241	40
41	Income before Income Taxes (line 30 minus line 40)**	351,573	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 351,573	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 South Nursing Home

0023242

Report Period Beginning:

01/01/07

Ending:

12/31/07

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,048	2,080	\$ 78,517	\$ 37.75	1
2	Assistant Director of Nursing	2,080	2,080	60,626	29.15	2
3	Registered Nurses	26,362	27,977	725,384	25.93	3
4	Licensed Practical Nurses	43,433	45,255	1,020,820	22.56	4
5	CNAs & Orderlies	120,630	129,491	1,767,139	13.65	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,928	2,139	41,401	19.36	9
10	Activity Assistants	13,951	15,115	213,659	14.14	10
11	Social Service Workers	5,321	5,563	77,718	13.97	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	14,935	15,536	209,461	13.48	17
18	Housekeepers	14,936	16,263	195,901	12.05	18
19	Laundry	12,146	12,781	141,411	11.06	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,871	2,041	38,908	19.06	23
24	Clerical	22,249	23,764	333,931	14.05	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	1,945	2,201	31,525	14.32	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	283,835	302,286	\$ 4,936,401 *	\$ 16.33	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 12,000	9(3)	36
37	Medical Records Consultant	Monthly 4,374	10(3)	37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 1,666	10(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	Monthly 4,272	12(3)	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 22,312		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,185	\$ 75,637	10(3)	50
51	Licensed Practical Nurses	1,850	74,373	10(3)	51
52	Certified Nurse Assistants/Aides	3,373	118,598	10(3)	52
53	TOTAL (lines 50 - 52)	6,408	\$ 268,608		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Rest Haven South Nursing Home**

0023242

Report Period Beginning: **01/01/07**

Ending: **12/31/07**

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	
Evelyn Hanna	Administrator		\$ 104,216	Workers' Compensation Insurance	\$ 109,837	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	23,771	Advertising: Employee Recruitment	1,082	
				FICA Taxes	361,970	Health Care Worker Background Check	8,060	
				Employee Health Insurance	213,285	(Indicate # of checks performed <u>332</u>)		
Amount paid out of Home Office allocated in column 7				Employee Meals	0	Patient Background Checks		
				TDA Expense	66,804	Life Services Network	10,956	
				Drug Testing	5,254	JCAHO	4,085	
				Employee Welfare	55,437	Miscellaneous Subscriptions	1,059	
				Employee Medical	218	Miscellaneous Licenses & Fees	859	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 104,216	Other Emp Benefits	1,409	Allocated from Home Office	8,109	
				Uniforms	3,625	Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 841,610	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 36,200	
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)			\$ 982,140	N/A		\$	Out-of-State Travel	\$
							In-State Travel	1,679
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 982,140				Seminar Expense	
							See Attached Schedule	4,638
C. Professional Services							Allocated from Home Office	11,987
Vendor/Payee	Type		Amount				Entertainment Expense	()
RSM McGladrey	Accounting		\$ 5,855				(agree to Sch. V, line 24, col. 8)	
KPMG LLP	Accounting		4,855				TOTAL	\$ 18,304
Achieve Accreditation	Operations Consulting		4,756					
Cressa Perish, MD	Clinical Consulting		200					
DaRT Chart System	Clinical Consulting		130,754					
JMA Architects	Architect Fees		880					
Sachnoff & Weaver LTD	Legal Fees		124					
Reed Smith Sachoff&Weaver	Legal Fees		8,643					
M.G.R Legal Filing/Title Services	Legal Fees		248					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 156,315	TOTAL		\$		

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Rest Haven South Nursing Home

Provider #: 0023242

01/01/07 to 12/31/07

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

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

156,315

Allocated from Home Office

Other

3,212

3,212

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

159,527

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								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2004	FY2005	FY2006	FY2007
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								
2																				
3																				
4							N/A													
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven South Nursing Home

0023242

Report Period Beginning:

01/01/07

Ending:

12/31/07

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. LSN&JCAHO \$15,041
- (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? 5 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 180,017 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.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department 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.

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. \$ 87
- (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? N/A
- 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? 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, 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 \$5,000, 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