



Facility Name & ID Number Rest Haven West Christian Nursing Center

# 0028605 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	145	Skilled (SNF)	145	52,925	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	96	Sheltered Care (SC)	96	35,040	5
6		ICF/DD 16 or Less			6
7	241	TOTALS	241	87,965	7

B. Census-For the entire report period.

	1 Level of Care	3 Patient Days by Level of Care and Primary Source of Payment				5 Total
		2 Medicaid Recipient	Private Pay	4 Other		
8	SNF	16,512	14,364	15,379	46,255	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		25,571		25,571	12
13	DD 16 OR LESS					13
14	TOTALS	16,512	39,935	15,379	71,826	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.65%

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 05/01/1984

J. Was the facility purchased or leased after January 1, 1978?  
 YES  Date 05/01/1984 NO

K. Was the facility certified for Medicare during the reporting year?  
 YES  NO  If YES, enter number of beds certified 145 and days of care provided 15,379

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 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		18,730	955,878	974,608		974,608		974,608		1
2	Food Purchase		587,099		587,099		587,099	13,282	600,381		2
3	Housekeeping	191,227	45,019		236,246		236,246		236,246		3
4	Laundry	26,237	121,044		147,281		147,281		147,281		4
5	Heat and Other Utilities			293,542	293,542		293,542	18,801	312,343		5
6	Maintenance	196,439		233,730	430,169		430,169	(38,890)	391,279		6
7	Other (specify):* <b>Mgmt. Alloc. Benefits</b>							869	869		7
8	<b>TOTAL General Services</b>	413,903	771,892	1,483,150	2,668,945		2,668,945	(5,938)	2,663,007		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			16,576	16,576		16,576		16,576		9
10	Nursing and Medical Records	3,447,204	303,395	725,657	4,476,256		4,476,256		4,476,256		10
10a	Therapy			1,035,540	1,035,540		1,035,540		1,035,540		10a
11	Activities	157,963	33,166	793	191,922		191,922		191,922		11
12	Social Services	186,309	376	3,989	190,674		190,674		190,674		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	3,791,476	336,937	1,782,555	5,910,968		5,910,968		5,910,968		16
	<b>C. General Administration</b>										
17	Administrative			1,168,104	1,168,104		1,168,104	(1,028,522)	139,582		17
18	Directors Fees										18
19	Professional Services			194,164	194,164		194,164	3,193	197,357		19
20	Dues, Fees, Subscriptions & Promotions			26,641	26,641		26,641	6,511	33,152		20
21	Clerical & General Office Expenses	613,723	36,885	65,098	715,706		715,706	478,030	1,193,736		21
22	Employee Benefits & Payroll Taxes			796,142	796,142		796,142		796,142		22
23	Inservice Training & Education			915	915		915		915		23
24	Travel and Seminar			4,692	4,692		4,692	11,916	16,608		24
25	Other Admin. Staff Transportation			3,654	3,654		3,654	5,822	9,476		25
26	Insurance-Prop.Liab.Malpractice			183,265	183,265		183,265	7,327	190,592		26
27	Other (specify):* <b>Mgmt. Alloc. Benefits</b>							132,061	132,061		27
28	<b>TOTAL General Administration</b>	613,723	36,885	2,442,675	3,093,283		3,093,283	(383,662)	2,709,621		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	4,819,102	1,145,714	5,708,380	11,673,196		11,673,196	(389,600)	11,283,596		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 West Christian Nursing Center

#0028605

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			673,365	673,365		673,365	(113,658)	559,707			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			506,287	506,287		506,287	22,417	528,704			32
33	Real Estate Taxes			14,460	14,460		14,460	(3,310)	11,150			33
34	Rent-Facility & Grounds							6,266	6,266			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,194,112	1,194,112		1,194,112	(88,285)	1,105,827			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		828,940		828,940		828,940		828,940			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			79,388	79,388		79,388		79,388			42
43	Other (specify):* <b>Non-allowable Cos</b>			550,569	550,569		550,569	(550,569)				43
44	<b>TOTAL Special Cost Centers</b>		828,940	629,957	1,458,897		1,458,897	(550,569)	908,328			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,819,102	1,974,654	7,532,449	14,326,205		14,326,205	(1,028,454)	13,297,751			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	(5,956)	2		4
5	Telephone, TV & Radio in Resident Rooms	(15,798)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(173,812)	30		9
10	Interest and Other Investment Income	(74)	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	(17,900)	43		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				24
25	Fund Raising, Advertising and Promotional	(31,632)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(38,602)	43		28
29	Other-Attach Schedule See Pg. 5A	(490,830)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (774,604)		\$	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)	(253,850)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (253,850)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (1,028,454)		37

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

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

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

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' COMPILATION REPORT

Rest Haven West Christian Nursing Center

ID# 0028605

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Disallowed Non-Care Related Real Estate Taxes	\$ (14,460)	33	1
2	Disallow Laboratory Expense	(31,366)	43	2
3	Disallow Interehab Psychiatry	(91,220)	43	3
4	Disallow X-Ray Expense	(30,271)	43	4
5	Disallow Residents Welfare	(6,842)	43	5
6	Disallow Marketing Costs	(282,302)	43	6
7	Disallow Accretion Expense	(2,387)	43	7
8	Disallow Free Care Contractual	(16,652)	43	8
9	Disallow Chamber of Commerce Dues	(1,550)	20	9
10	To Capitalize R&M Items per HFS rules	(9,593)	6	10
11	Disallow Life Line Expense	(107)	43	11
12	Disallow non-allowable interest	(2,792)	32	12
13	Disallow Day Care Expense	(1,288)	43	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(490,830)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rest Haven West Christian Nursing Center# 0028605

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	(5,956)	16,107	0	3,131	0	0	0	0	0	0	0	13,282	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	15,741	0	3,060	0	0	0	0	0	0	0	18,801	5
6	Maintenance	(9,593)	(14,891)	0	(14,575)	0	0	0	0	0	0	0	(39,059)	6
7	Other (specify):*	0	869	0	169	0	0	0	0	0	0	0	1,038	7
8	<b>TOTAL General Services</b>	<b>(15,549)</b>	<b>17,826</b>	<b>0</b>	<b>(8,215)</b>	<b>0</b>	<b>(5,938)</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	(880,736)	0	(147,786)	0	0	0	0	0	0	0	(1,028,522)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	2,673	0	520	0	0	0	0	0	0	0	3,193	19
20	Fees, Subscriptions & Promotions	(1,550)	6,749	0	1,312	0	0	0	0	0	0	0	6,511	20
21	Clerical & General Office Expenses	(15,798)	413,449	0	80,379	0	0	0	0	0	0	0	478,030	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	9,976	0	1,940	0	0	0	0	0	0	0	11,916	24
25	Other Admin. Staff Transportation	0	4,874	0	948	0	0	0	0	0	0	0	5,822	25
26	Insurance-Prop.Liab.Malpractice	0	0	6,134	1,193	0	0	0	0	0	0	0	7,327	26
27	Other (specify):*	0	0	110,566	21,495	0	0	0	0	0	0	0	132,061	27
28	<b>TOTAL General Administration</b>	<b>(17,348)</b>	<b>(443,015)</b>	<b>116,700</b>	<b>(39,999)</b>	<b>0</b>	<b>(383,662)</b>	<b>28</b>						
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(32,897)</b>	<b>(425,189)</b>	<b>116,700</b>	<b>(48,214)</b>	<b>0</b>	<b>(389,600)</b>	<b>29</b>						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 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	(173,812)	0	50,362	9,792	0	0	0	0	0	0	0	(113,658)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,866)	0	21,168	4,115	0	0	0	0	0	0	0	22,417	32
33	Real Estate Taxes	(14,460)	0	9,335	1,815	0	0	0	0	0	0	0	(3,310)	33
34	Rent-Facility & Grounds	0	0	5,246	1,020	0	0	0	0	0	0	0	6,266	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>(191,138)</b>	<b>0</b>	<b>86,111</b>	<b>16,742</b>	<b>0</b>	<b>(88,285)</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):*	(550,569)	0	0	0	0	0	0	0	0	0	0	(550,569)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(550,569)</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>(550,569)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(774,604)</b>	<b>(425,189)</b>	<b>202,811</b>	<b>(31,472)</b>	<b>0</b>	<b>(1,028,454)</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%	\$ 16,107	\$	16,107	1
2	V	5 <u>Utilities</u>		<u>Rest Haven Illiana Christian Convalescent Home</u>	100.00%	15,741		15,741	2
3	V	6 <u>Maintenance - Salary</u>		<u>Rest Haven Illiana Christian Convalescent Home</u>	100.00%	3,715		3,715	3
4	V	6 <u>Maintenance - other</u>	27,015	<u>Rest Haven Illiana Christian Convalescent Home</u>	100.00%	8,409		(18,606)	4
5	V	7 <u>Mgmt. allocation of benefits</u>		<u>Rest Haven Illiana Christian Convalescent Home</u>	100.00%	869		869	5
6	V	17 <u>Administrative</u>	967,680	<u>Rest Haven Illiana Christian Convalescent Home</u>	100.00%	86,944		(880,736)	6
7	V	19 <u>Professional services - Legal</u>		<u>Rest Haven Illiana Christian Convalescent Home</u>	100.00%				7
8	V	19 <u>Professional services - Other</u>		<u>Rest Haven Illiana Christian Convalescent Home</u>	100.00%	2,673		2,673	8
9	V	20 <u>Dues, fees &amp; subscriptions</u>		<u>Rest Haven Illiana Christian Convalescent Home</u>	100.00%	6,749		6,749	9
10	V	21 <u>Clerical &amp; general - salary</u>		<u>Rest Haven Illiana Christian Convalescent Home</u>	100.00%	366,276		366,276	10
11	V	21 <u>Clerical &amp; general - other</u>		<u>Rest Haven Illiana Christian Convalescent Home</u>	100.00%	47,173		47,173	11
12	V	24 <u>Travel &amp; seminar</u>		<u>Rest Haven Illiana Christian Convalescent Home</u>	100.00%	9,976		9,976	12
13	V	25 <u>Other Admin. Staff transportation</u>		<u>Rest Haven Illiana Christian Convalescent Home</u>	100.00%	4,874		4,874	13
14	Total		\$ 994,695			\$ 569,506	\$ *	(425,189)	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%	\$ 6,134	\$	6,134	15
16	V	27 Mgmt. allocation of benefits		Rest Haven Illiana Christian Convalescent Home	100.00%	110,566		110,566	16
17	V	30 Depreciation		Rest Haven Illiana Christian Convalescent Home	100.00%	50,362		50,362	17
18	V	32 Interest		Rest Haven Illiana Christian Convalescent Home	100.00%	21,168		21,168	18
19	V	33 Real Estate Taxes		Rest Haven Illiana Christian Convalescent Home	100.00%	9,335		9,335	19
20	V	34 Rent - facility & grounds		Rest Haven Illiana Christian Convalescent Home	100.00%	5,246		5,246	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		\$			\$ 202,811	\$ *	202,811	39

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

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	2 Food	\$	Rest Haven Illiana Christian Convalescent Home	100.00%	\$ 3,131	\$	3,131	15
16	V	5 Utilities		Rest Haven Illiana Christian Convalescent Home	100.00%	3,060		3,060	16
17	V	6 Maintenance - Salary		Rest Haven Illiana Christian Convalescent Home	100.00%	722		722	17
18	V	6 Maintenance - other	16,932	Rest Haven Illiana Christian Convalescent Home	100.00%	1,635		(15,297)	18
19	V	7 Mgmt. allocation of benefits		Rest Haven Illiana Christian Convalescent Home	100.00%	169		169	19
20	V	17 Administrative	200,424	Rest Haven Illiana Christian Convalescent Home	100.00%	52,638		(147,786)	20
21	V	19 Professional services - Legal		Rest Haven Illiana Christian Convalescent Home	100.00%				21
22	V	19 Professional services - Other		Rest Haven Illiana Christian Convalescent Home	100.00%	520		520	22
23	V	20 Dues, fees & subscriptions		Rest Haven Illiana Christian Convalescent Home	100.00%	1,312		1,312	23
24	V	21 Clerical & general - salary		Rest Haven Illiana Christian Convalescent Home	100.00%	71,208		71,208	24
25	V	21 Clerical & general - other		Rest Haven Illiana Christian Convalescent Home	100.00%	9,171		9,171	25
26	V	24 Travel & seminar		Rest Haven Illiana Christian Convalescent Home	100.00%	1,940		1,940	26
27	V	25 Other Admin. Staff transportation		Rest Haven Illiana Christian Convalescent Home	100.00%	948		948	27
28	V	26 Insurance - Prop., Liab & Malpractice		Rest Haven Illiana Christian Convalescent Home	100.00%	1,193		1,193	28
29	V	27 Mgmt. allocation of benefits		Rest Haven Illiana Christian Convalescent Home	100.00%	21,495		21,495	29
30	V	30 Depreciation		Rest Haven Illiana Christian Convalescent Home	100.00%	9,792		9,792	30
31	V	32 Interest		Rest Haven Illiana Christian Convalescent Home	100.00%	4,115		4,115	31
32	V	33 Real Estate Taxes		Rest Haven Illiana Christian Convalescent Home	100.00%	1,815		1,815	32
33	V	34 Rent - facility & grounds		Rest Haven Illiana Christian Convalescent Home	100.00%	1,020		1,020	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 217,356			\$ 185,884	\$ *	(31,472)	39

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

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 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	N/A - Voluntary Board with no compensation. See Attached Schedule 7A										5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center

# 0028605

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	88,072,344	18	\$ 129,406	\$ 10,962,123	\$ 16,107	1	
2	5	Utilities	Accumulated cost B	88,072,344	18	126,470	10,962,123	15,741	2	
3	6	Maintenance - Salary	Accumulated cost B	88,072,344	18	29,844	29,844	10,962,123	3,715	3
4	6	Maintenance - other	Accumulated cost B	88,072,344	18	67,558	10,962,123	8,409	4	
5	7	Mgmt. allocation of benefits	Accumulated cost B	88,072,344	18	6,979	10,962,123	869	5	
6	17	Administrative	Direct cost	1	1	856,112	86,944	1	86,944	6
7	19	Professional Services - Legal	Accumulated cost B	88,072,344	18	0	10,962,123	0	7	
8	19	Professional Services - Other	Accumulated cost B	88,072,344	18	21,475	10,962,123	2,673	8	
9	20	Dues, Fees & Subscriptions	Accumulated cost B	88,072,344	18	54,221	10,962,123	6,749	9	
10	21	Clerical & general - salary	Accumulated cost B	88,072,344	18	2,942,747	2,942,747	10,962,123	366,276	10
11	21	Clerical & general - other	Accumulated cost B	88,072,344	18	378,998	10,962,123	47,173	11	
12	24	Travel & seminar	Accumulated cost B	88,072,344	18	80,152	10,962,123	9,976	12	
13	25	Other admin. Staff transportation	Accumulated cost B	88,072,344	18	39,162	10,962,123	4,874	13	
14	26	Insurance - prop., liab. & malprac	Accumulated cost B	88,072,344	18	49,285	10,962,123	6,134	14	
15	27	Mgmt. allocation of benefits	Accumulated cost B	88,072,344	18	888,311	10,962,123	110,566	15	
16	30	Depreciation	Accumulated cost B	88,072,344	18	404,615	10,962,123	50,362	16	
17	32	Interest Expense	Accumulated cost B	88,072,344	18	170,066	10,962,123	21,168	17	
18	33	Real Estate Taxes	Accumulated cost B	88,072,344	18	75,000	10,962,123	9,335	18	
19	34	Rent - Facility & grounds	Accumulated cost B	88,072,344	18	42,149	10,962,123	5,246	19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 6,362,550	\$ 3,059,535	\$ 772,317	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center

# 0028605

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	88,072,344	18	\$ 129,406	2,131,159	\$ 3,131	1
2	5	Utilities	Accumulated cost B	88,072,344	18	126,470	2,131,159	3,060	2
3	6	Maintenance - Salary	Accumulated cost B	88,072,344	18	29,844	29,844	722	3
4	6	Maintenance - other	Accumulated cost B	88,072,344	18	67,558	2,131,159	1,635	4
5	7	Mgmt. allocation of benefits	Accumulated cost B	88,072,344	18	6,979	2,131,159	169	5
6	17	Administrative	Direct cost	1	1	856,112	52,638	1	52,638
7	19	Professional Services - Legal	Accumulated cost B	88,072,344	18		2,131,159		7
8	19	Professional Services - Other	Accumulated cost B	88,072,344	18	21,475	2,131,159	520	8
9	20	Dues, Fees & Subscriptions	Accumulated cost B	88,072,344	18	54,221	2,131,159	1,312	9
10	21	Clerical & general - salary	Accumulated cost B	88,072,344	18	2,942,747	2,942,747	71,208	10
11	21	Clerical & general - other	Accumulated cost B	88,072,344	18	378,998	2,131,159	9,171	11
12	24	Travel & seminar	Accumulated cost B	88,072,344	18	80,152	2,131,159	1,940	12
13	25	Other admin. Staff transportation	Accumulated cost B	88,072,344	18	39,162	2,131,159	948	13
14	26	Insurance - prop., liab. & malprac	Accumulated cost B	88,072,344	18	49,285	2,131,159	1,193	14
15	27	Mgmt. allocation of benefits	Accumulated cost B	88,072,344	18	888,311	2,131,159	21,495	15
16	30	Depreciation	Accumulated cost B	88,072,344	18	404,615	2,131,159	9,792	16
17	32	Interest Expense	Accumulated cost B	88,072,344	18	170,066	2,131,159	4,115	17
18	33	Real Estate Taxes	Accumulated cost B	88,072,344	18	75,000	2,131,159	1,815	18
19	34	Rent - Facility & grounds	Accumulated cost B	88,072,344	18	42,149	2,131,159	1,020	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 6,362,550	\$ 3,025,229	\$ 185,884	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center

# 0028605

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**					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	Additions & Renovations	Varies	11/01/04	\$ 9,450,000	\$ 8,802,675	10/31/34	Variable	\$ 505,436	1					
2	Notes		X	Facility Improvements	Varies	Various	763,564		Various	Variable	851	2					
3												3					
4												4					
5												5					
<b>Working Capital</b>																	
6												6					
7												7					
8												8					
9	<b>TOTAL Facility Related</b>						\$ 10,213,564	\$ 8,802,675			\$ 506,287	9					
<b>B. Non-Facility Related*</b>																	
10									Allocated from Home Office		25,283	10					
11									Disallow non-care related interest		(2,792)	11					
12									Interest Income Offset		(74)	12					
13												13					
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 22,417	14					
15	<b>TOTALS (line 9+line14)</b>						\$ 10,213,564	\$ 8,802,675			\$ 528,704	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	\$	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>		Allocated from Home Office		11,150
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	11,150
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 company.</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 West Christian Nursing Center COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0028605

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>19-09-01-203-003-0000</u>	<u>Home Office Building</u>	\$ <u>65,165.32</u>	\$ <u>11,150.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>65,165.32</u>	\$ <u>11,150.00</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.

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 105,900 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).

N/A

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: N/A

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Resident Care</u>	<u>29,200</u>	<u>1984</u>	<u>\$ 339,570</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>29,200</b>		<b>\$ 339,570</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Rest Haven West Christian Nursing Center

# 0028605

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	241	1984	1962	\$ 86,903	\$	40	\$	\$	\$ 86,903	4
5			1972	889,527	22,238	40	22,238		800,568	5
6			1976	34,742	869	40	869		30,415	6
7			1974	7,414	185	40	185		6,290	7
8			1975	55,878	1,397	40	1,397		46,101	8
<b>Improvement Type**</b>										
9	Improvement		1976	4,115	103	40	103		3,296	9
10	Improvement		1977	33,527	838	40	838		25,978	10
11	Improvement		1980	6,049	151	40	151		4,228	11
12	Improvement		1981	7,380	185	40	185		4,995	12
13	Improvement		1983	22,839	571	40	571		14,275	13
14	Improvement		1984	253,714	9,250	40	9,250		194,403	14
15	Improvement		1985	297,491	7,437	40	7,437		171,051	15
16	Improvement		1986	275,406	6,885	40	6,885		151,470	16
17	Improvement		1987	24,035	601	40	601		12,621	17
18	Improvement		1988	509,896	12,747	40	12,747		254,940	18
19	Improvement		1989	4,381,420	109,536	40	109,536		2,081,184	19
20	Improvement		1989	90,660	2,267	40	2,267		43,073	20
21	Improvement		1990	155,196	3,880	40	3,880		69,840	21
22	Improvement		1991	5,021	126	40	126		2,142	22
23	Improvement		1992	75,453	1,886	40	1,886		30,176	23
24	Improvement		1993	26,281	657	40	657		9,855	24
25	Improvement		1994	16,231	405	40	405		5,670	25
26	Improvement		1995	128,962	3,224	40	3,224		40,300	26
27	Sign and landscaping		1996	4,764	119	40	119		1,369	27
28	Fence		1996	1,565	40	40	40		460	28
29	Renovate laundry and break rooms		1996	4,400	110	40	110		1,265	29
30	Whirlpool tubs		1996	20,200	505	40	505		5,807	30
31	Side rail		1996	2,293	57	40	57		656	31
32	Phone system		1996	35,085	877	40	877		17,908	32
33	Parking lot		1997	15,078	377	40	377		3,959	33
34	Landscaping		1997	10,839	271	40	271		2,845	34
35	Dining room renovation		1997	1,193	30	40	30		315	35
36			1997	34,830	871	40	871		9,145	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 West Christian Nursing Center

# 0028605

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	Activity / class room renovation	1997	\$ 3,476	\$ 87	40	\$ 87		\$ 913	37
38	Carpeting	1997	1,521	38	40	38		399	38
39	Railing	1997	500	13	40	13		136	39
40	Laundry / break room renovation	1998	6,864	172	40	172		1,634	40
41	Compressor	1998	917	92	10	92		874	41
42	Roof repair	1998	2,320	232	10	232		2,204	42
43	Alarm system	1998	1,056	106	10	106		1,007	43
44	Hospitality room renovation	1998	12,605	316	40	316		3,002	44
45	Carpeting	1998	76,503		5	(22,959)	(22,959)	76,503	45
46	Wallpaper	1998	40,287		5	(12,078)	(12,078)	40,287	46
47	Roofing	1999	208,749	20,874	10	20,874		177,429	47
48	Therapy room renovation	1999	23,731	2,374	10	2,374		20,179	48
49	Resident room lighting	1999	23,965	2,397	10	2,397		20,372	49
50	Phone upgrade	1999	2,470	248	10	248		2,108	50
51	Renovations	1999	47,385	4,738	10	4,738		40,275	51
52	New door on oxygen room	1999	1,993	194	10	194		1,650	52
53	Landscaping	2000	59,350	1,484	40	1,484		11,130	53
54	Benches	2000	2,500	63	40	63		472	54
55	Room 18 renovation , wallcover, painting, tiling and carpet	2000	7,682	768	10	768		5,760	55
56	Therapy room renovation, wallcover, painting and tiling	2000	28,849	2,885	10	2,885		21,637	56
57	Beauty renovation, wallcover, painting, tiling and carpeting	2000	31,764	3,176	10	3,176		23,820	57
58	Common renovation, wallcover, painting, tiling and carpteing	2000	36,699	4,231	10	3,670	(561)	29,489	58
59	Kitchen renovation, wallcover, painting and tiling	2000	24,995	2,500	10	2,500		18,750	59
60	HVAC	2000	32,028	3,203	10	3,203		24,022	60
61	Doors	2000	3,300	330	10	330		2,475	61
62	Countertop	2000	654	65	10	65		488	62
63									63
64									64
65	Room renovation	2001	1,124,343	112,434	10	112,434		799,346	65
66	Rehab renovation	2001	82,557	9,808	10	8,256	(1,552)	57,544	66
67	Nurse call system	2001	114,755	11,476	10	11,476		74,594	67
68	Kitchen renovations	2001	3,800	380	10	380		2,470	68
69	HVAC	2001	3,000	300	10	300		1,950	69
70	TOTAL (lines 4 thru 69)		\$ 9,529,005	\$ 373,679		\$ 336,529	\$ (37,150)	\$ 5,596,422	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 West Christian Nursing Center

# 0028605

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>		\$ 9,529,005	\$ 373,679		\$ 336,529	\$ (37,150)	\$ 5,596,422	1
2	Doors	2001	3,187	319	10	319		2,073	2
3	Office remodeling	2001	35,071	3,507	10	3,507		22,796	3
4	HVAC	2001	28,200	2,820	10	2,820		18,330	4
5									5
6	landscaping	2002	25,539	2,554	10	2,554		14,047	6
7	Fence	2002	4,675	468	10	468		2,575	7
8	Nurse Call Station Renovation	2002	26,950	2,695	40	674	(2,021)	3,707	8
9	HVAC	2002	12,424	1,242	40	311	(931)	1,710	9
10									10
11	Renovations	2002	33,960	3,396	40	849	(2,547)	4,669	11
12	New Therapy Addition	2002	69,218	6,922	40	1,730	(5,192)	9,672	12
13	Landscaping	2001	10,400	1,040	40	260	(780)	1,430	13
14	Repair R3000 System	2002	3,922	98	40	98		539	14
15	Carpeting	2002	9,713	243	40	243		1,336	15
16	Bathroom remodeling	2003	12,350	618	20	618		2,781	16
17	Wallcoverings	2003	36,922	923	40	923		4,154	17
18	Floorcoverings	2003	42,356	1,059	40	1,059		4,765	18
19	Curtains and Blinds	2003	65,815	1,645	40	1,645		7,403	19
20	Landscaping and Fencing	2003	150,886	3,772	40	3,772		16,974	20
21	Parking, Curbs, and Sidewalks	2003	276,160	6,904	40	6,904		31,068	21
22	PT Wing / New Entry / New Admin. Offices	2003	1,754,047	55,699	40	43,852	(11,847)	203,257	22
23	Signage	2003	9,043	904	10	904		4,068	23
24	Gazebo	2003	5,436	272	20	272		1,122	24
25									25
26	Shelving	2003	1,328	133	10	133		598	26
27	Nurse call system	2004	33,450	3,345	10	3,345		11,708	27
28	Bath tub resurfacing	2004	4,750	238	20	238		833	28
29	Alzheimer Unit Renovation	2004	77,906	1,948	40	1,948		6,818	29
30	Fire Alarm	2004	1,795	180	10	180		668	30
31	Lighting	2004	501	50	10	50		186	31
32	Carpet	2004	2,374	237	10	237		881	32
33	Cabinets	2004	2,626	263	10	263		977	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 12,270,009	\$ 477,173		\$ 416,705	\$ (60,468)	\$ 5,977,567	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 West Christian Nursing Center

# 0028605

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>		\$ 12,270,009	\$ 477,173		\$ 416,705	\$ (60,468)	\$ 5,977,567	1
2	Water heater	2004	2,997	300	10	300		1,050	2
3	Dentist office	2004	8,981	224	40	224		784	3
4	Expansion	2004	1,928	48	40	48		168	4
5									5
6	Carpeting	2005	2,050	205	10	205		513	6
7	Thermostats	2005	4,500	300	15	300		750	7
8	Handrails	2005	1,375	92	15	92		230	8
9	Sidewalks	2005	10,927	546	20	546		1,365	9
10	Bath Tub Conversions	2005	5,700	390	15	390		970	10
11	Carpeting	2005	7,904	1,130	7	1,130		2,825	11
12	Chiller	2005	6,101	306	20	306		765	12
13	Paving	2005	19,642	982	20	982		2,455	13
14	Boilers & HVAC	2005	13,435	672	20	672		1,680	14
15	Storage Tank & Water Lines	2005	1,125	56	20	56		140	15
16	Chiller	2005	540	28	20	28		70	16
17	Carpeting	2005	3,040	434	7	434		1,085	17
18	Smoke Detectors	2005	2,316	116	20	116		290	18
19	Generator	2005	1,122	56	20	56		140	19
20									20
21	Asbestos Retirement Obligation - West	2006	39,569		7	5,652	5,652	8,478	21
22	Sirens - West	2006	3,063	438	7	438		657	22
23	Door Alarm System - West	2006	33,453	3,346	10	3,346		5,019	23
24	West Office Remodel - West	2006	19,770	988	20	988		1,482	24
25	Heat A/C Valve - West	2006	4,400	294	15	294		441	25
26	Grading & Sodding of Front lawn - West	2006	5,060	338	15	338		507	26
27	Asbestos Retirement Obligation - Saratoga Grove	2006	9,695	1,386	7	1,386		2,079	27
28	Boilers	2006	37,695	2,512	15	2,512		3,768	28
29	Reception area renovation	2006	6,500	434	15	434		651	29
30	Gift Shop Lighting & Fixtures	2006	29,057	1,452	20	1,452		2,178	30
31	Office & Exit Doors	2006	5,164	258	20	258		387	31
32	Carpeting	2006	7,138	1,102	7	1,020	(82)	1,530	32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 12,564,256	\$ 495,606		\$ 440,708	\$ (54,898)	\$ 6,020,024	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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>		\$ 12,564,256	\$ 495,606		\$ 440,708	\$ (54,898)	\$ 6,020,024	1
2	Door Repair - West	2007	5,670	142	20	142		142	2
3	Phone System - West	2007	70,262	3,513	10	3,513		3,513	3
4	Boiler	2007	9,686	323	15	323		323	4
5	Electrical Work - West	2007	3,120	78	20	78		78	5
6	Door Alarm Enhancement - West	2007	16,695	835	10	835		835	6
7	A/C Unit - West	2007	11,550	385	15	385		385	7
8	Water Heater - West	2007	9,370	312	15	312		312	8
9	Carpeting for Resident Rooms - West	2007	3,221	230	7	230		230	9
10	Rooftop HVAC unit	2007	15,300	510	15	510		510	10
11	Phone System - Saratoga Grove	2007	46,842	2,342	10	2,342		2,342	11
12	Replace bathtubs in 11 resident rooms - Saratoga Grove	2007	5,500	183	15	183		183	12
13	A/C Valve & ductwork replacement - Saratoga Grove	2007	6,227	156	20	156		156	13
14	Carpeting for Resident Rooms - Saratoga Grove	2007	15,453	1,104	7	1,104		1,104	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	Allocation from Home Office		623,269			22,079	22,079	87,470	31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 13,406,421	\$ 505,719		\$ 472,900	\$ (32,819)	\$ 6,117,607	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	\$ 3,298,452	\$ 167,080	\$ 48,168	\$ (118,912)	3-10	\$ 3,210,615	71
72	Current Year Purchases	11,329	566	566		10	566	72
73	Fully Depreciated Assets							73
74	Allocation from Home Office	564,959		35,321	35,321		460,410	74
75	TOTALS	\$ 3,874,740	\$ 167,646	\$ 84,055	\$ (83,591)		\$ 3,671,591	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	Resident care	1984 Ford Bus	1989	\$ 47,590	\$	\$	\$	5	\$ 47,590	76
77	Resident care	1995 Chevrolet K20 Truck	1995	22,494				5	22,494	77
78										78
79	Allocation from home office			5,819		2,752	2,752		5,516	79
80	TOTALS			\$ 75,903	\$	\$ 2,752	\$ 2,752		\$ 75,600	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)	\$ 17,696,634	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 673,365	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 559,707	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (113,658)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 9,864,798	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			6,266			6
7	TOTAL			\$ 6,266			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 \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ N/A Description: \_\_\_\_\_

(Attach a schedule detailing the breakdown of movable equipment)

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

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	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	10A(2,3)	hrs	\$	7,063	\$ 423,770	\$	7,063	\$ 423,770	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,626	157,531	438	2,626	157,969	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		7,563	453,801		7,563	453,801	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				828,940		828,940	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>			\$	17,252	\$ 1,035,102	\$ 829,378	17,252	\$ 1,864,480	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 West Christian Nursing Center

# 0028605

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	\$ 34,087	\$ 34,087	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,762,700	1,762,700	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	23,074	23,074	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,819,861	\$ 1,819,861	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	358,918	339,570	13
14	Buildings, at Historical Cost	14,577,235	13,406,421	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,458,506	3,950,643	16
17	Accumulated Depreciation (book methods)	(9,877,684)	(9,864,798)	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 (sum of lines 11 thru 23)</b>	\$ 8,516,975	\$ 7,831,836	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 10,336,836	\$ 9,651,697	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 228,594	\$ 228,594	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,704	1,704	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	76,098	76,098	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,000	20,000	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 Related Parties</b>	6,878,469	6,878,469	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 7,204,865	\$ 7,204,865	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable		8,802,675	41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<b>Other Long-Term Liabilities</b>	81,944	81,944	43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 81,944	\$ 8,884,619	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 7,286,809	\$ 16,089,484	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 3,050,027	\$ (6,437,787)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 10,336,836	\$ 9,651,697	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>2,934,647</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>	<b>Prior period adjustment</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>2,934,647</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>115,378</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>Rounding</b>	<b>2</b>	<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>115,380</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>3,050,027</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	\$ 13,553,828	1
2	Discounts and Allowances for all Levels	(3,070,287)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 10,483,541	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,564,998	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 2,564,998	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	6,859	13
14	Non-Patient Meals	5,956	14
15	Telephone, Television and Radio	15,798	15
16	Rental of Facility Space		16
17	Sale of Drugs	803,862	17
18	Sale of Supplies to Non-Patients	331,002	18
19	Laboratory	77,650	19
20	Radiology and X-Ray	43,016	20
21	Other Medical Services	43,008	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 1,327,151	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions	21,600	24
25	Interest and Other Investment Income***	74	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 21,674	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Laundry - \$6,152; Misc. - \$38,067</u>	44,219	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 44,219	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 14,441,583	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	2,668,945	31
32	Health Care	5,910,968	32
33	General Administration	3,093,283	33
	<b>B. Capital Expense</b>		
34	Ownership	1,194,112	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	1,379,509	35
36	Provider Participation Fee	79,388	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 14,326,205	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	115,378	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 115,378	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 West Christian Nursing Center

# 0028605

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	2,072	2,080	\$ 78,950	\$ 37.96	1
2	Assistant Director of Nursing	4,144	4,160	125,656	30.21	2
3	Registered Nurses	51,494	52,889	1,083,284	20.48	3
4	Licensed Practical Nurses	21,233	22,014	362,415	16.46	4
5	CNAs & Orderlies	128,005	134,190	1,753,392	13.07	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,064	2,080	43,120	20.73	9
10	Activity Assistants	8,718	9,447	114,843	12.16	10
11	Social Service Workers	8,283	8,542	186,309	21.81	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	11,645	12,496	196,439	15.72	17
18	Housekeepers	15,639	16,460	191,227	11.62	18
19	Laundry	2,073	2,253	26,237	11.64	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,008	2,080	69,588	33.46	23
24	Clerical	32,972	35,309	544,135	15.41	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,316	2,476	43,507	17.57	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	292,664	306,475	\$ 4,819,102 *	\$ 15.72	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 16,576	9(3)	36
37	Medical Records Consultant	Monthly 4,224	10(3)	37
38	Nurse Consultant	Monthly 8,180	10(3)	38
39	Pharmacist Consultant	Monthly 1,595	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	Monthly 793	11(3)	44
45	Social Service Consultant	Monthly 494	12(3)	45
46	Other(specify) <u>Chapel Ministry</u>	Monthly 70	12(3)	46
47	<u>Psychology Consultant</u>	Monthly 2,250	12(3)	47
48				48
49	TOTAL (lines 35 - 48)	\$ 34,182		49

**C. CONTRACT NURSES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	12,250	\$ 619,129	10(3) 50
51	Licensed Practical Nurses	1,909	73,067	10(3) 51
52	Certified Nurse Assistants/Aides	493	18,216	10(3) 52
53	TOTAL (lines 50 - 52)	14,652	\$ 710,412	53

SEE ACCOUNTANTS' COMPILATION REPORT



**Rest Haven West Christian Nursing Center**

**Provider #: 0028605**

**1/1/2007 to 12/31/2007**

**Schedule 21A**

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3) 194,164

Plus: Home Office Allocation 3,193

Total (agree to Schedule V, line 19, column 8) 197,357

F. Dues, Fees, Subscriptions & Promotions

Life Services Network 14,191

DuPage County Health Dept. 850

JCAHO Fees 3,050

Miscellaneous Dues/Subscriptions 20

Miscellaneous License/Fees 1,411

Chamber of Commerce Dues 1,550

**Total** 21,072

**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			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2								N/A					
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 West Christian Nursing Center# 0028605Report 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 - \$14,191
- (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? \_\_\_\_\_
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 53,566 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 79,388  
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. \$ 5,956
- (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 still 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