

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNTY

0005785 Report Period Beginning: 9/1/06 Ending: 8/31/07

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 _____

	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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	49	Intermediate (ICF)	49	17,885	3
4		Intermediate/DD			4
5	25	Sheltered Care (SC)	25	9,125	5
6		ICF/DD 16 or Less			6
7	74	TOTALS	74	27,010	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					8
9	SNF/PED					9
10	ICF	7,360	10,320		17,680	10
11	ICF/DD					11
12	SC		7,305		7,305	12
13	DD 16 OR LESS					13
14	TOTALS	7,360	17,625		24,985	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.50%

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)
N/A

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

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 4/30/69

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 8/31/07 Fiscal Year: 8/31/07

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

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNT # 0005785 Report Period Beginning: 9/1/06 Ending: 8/31/07

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
1	A. General Services										
1	Dietary	204,245	19,836	6,042	230,123		230,123		230,123		1
2	Food Purchase		154,049		154,049		154,049	(5,456)	148,593		2
3	Housekeeping	99,655	15,353	2,356	117,364		117,364		117,364		3
4	Laundry	53,156	6,634	3,690	63,480		63,480		63,480		4
5	Heat and Other Utilities			80,755	80,755		80,755		80,755		5
6	Maintenance	57,304	8,518	14,737	80,559		80,559		80,559		6
7	Other (specify):*			1,846	1,846		1,846		1,846		7
8	TOTAL General Services	414,360	204,390	109,426	728,176		728,176	(5,456)	722,720		8
9	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	930,379	59,182	71,991	1,061,552		1,061,552		1,061,552		10
10a	Therapy	36,436		1,983	38,419		38,419		38,419		10a
11	Activities	97,945	5,949	9,788	113,682		113,682	(4,832)	108,850		11
12	Social Services	42,525	1,319	6,020	49,864		49,864		49,864		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,107,285	66,450	89,782	1,263,517		1,263,517	(4,832)	1,258,685		16
17	C. General Administration										
17	Administrative	77,019			77,019		77,019		77,019		17
18	Directors Fees										18
19	Professional Services			11,880	11,880		11,880		11,880		19
20	Dues, Fees, Subscriptions & Promotions			8,274	8,274		8,274	(3,973)	4,301		20
21	Clerical & General Office Expenses	64,473	10,214	14,192	88,879		88,879	(406)	88,473		21
22	Employee Benefits & Payroll Taxes			272,714	272,714		272,714		272,714		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,151	5,151		5,151		5,151		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			35,196	35,196		35,196		35,196		26
27	Other (specify):*										27
28	TOTAL General Administration	141,492	10,214	347,407	499,113		499,113	(4,379)	494,734		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,663,137	281,054	546,615	2,490,806		2,490,806	(14,667)	2,476,139		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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	
30	D. Ownership											
	Depreciation			83,656	83,656		83,656		83,656			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*			(110,236)	(110,236)		(110,236)	110,236				36
37	TOTAL Ownership			(26,580)	(26,580)		(26,580)	110,236	83,656			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			20,913	20,913		20,913		20,913			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			26,828	26,828		26,828		26,828			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			47,741	47,741		47,741		47,741			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,663,137	281,054	567,776	2,511,967		2,511,967	95,569	2,607,536			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

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	(5,456)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,832)	11		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	110,236	36		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,676)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,703)	var		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 95,569		\$	30

BHF USE ONLY							
48		49		50		51	
						52	

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 95,569		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

RESTHAVE HOME-WHITESIDE COUNTYID# 0005785Report Period Beginning: 9/1/06Ending: 8/31/07

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Cablevision	\$ (406)	21 1
2	IHCA DUES-PORION FOR LOBBYING	(1,297)	20 2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
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	(1,703)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNTY# 0005785

Report Period Beginning:

9/1/06

Ending:

8/31/07

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(5,456)	0	0	0	0	0	0	0	0	0	0	(5,456)	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	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(5,456)	0	0	0	0	0	0	0	0	0	0	(5,456)	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	(4,832)	0	0	0	0	0	0	0	0	0	0	(4,832)	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	(4,832)	0	0	0	0	0	0	0	0	0	0	(4,832)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(3,973)	0	0	0	0	0	0	0	0	0	0	(3,973)	20
21	Clerical & General Office Expenses	(406)	0	0	0	0	0	0	0	0	0	0	(406)	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	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(4,379)	0	0	0	0	0	0	0	0	0	0	(4,379)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(14,667)	0	0	0	0	0	0	0	0	0	0	(14,667)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNTY# 0005785

Report Period Beginning:

9/1/06

Ending:

8/31/07

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	110,236	0	0	0	0	0	0	0	0	0	0	110,236	36
37	TOTAL Ownership	110,236	0	0	0	0	0	0	0	0	0	0	110,236	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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	95,569	0	0	0	0	0	0	0	0	0	0	95,569	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
NONE						

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	N/A	\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNT # 0005785 Report Period Beginning: 9/1/06 Ending: 8/31/07

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	NONE								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number **RESTHAVE HOME-WHITESIDE COUNTY**

0005785

Report Period Beginning:

9/1/06

Ending: **8/31/07**

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 _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number

RESTHAVE HOME-WHITESIDE COUNTY

0005785

Report Period Beginning:

9/1/06

Ending:

8/31/07

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										
										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	NONE									1									
2										2									
3										3									
4										4									
5										5									
Working Capital																			
6										6									
7										7									
8										8									
9	TOTAL Facility Related				\$	\$			\$	9									
B. Non-Facility Related*																			
10										10									
11										11									
12										12									
13										13									
14	TOTAL Non-Facility Related				\$	\$			\$	14									
15	TOTALS (line 9+line14)				\$	\$			\$	15									

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

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

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNTY

0005785 Report Period Beginning:

9/1/06 Ending:

8/31/07

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 30,787 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 1

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>FACILITY LOCATION</u>	<u>354,835</u>	<u>1958 & 1964</u>	<u>\$ 10,977</u>	<u>1</u>
2	<u>CREEK STREET PROPERTY</u>	<u>2,500</u>	<u>2003</u>	<u>500</u>	<u>2</u>
3	TOTALS	357,335		\$ 11,477	3

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNTY

0005785

Report Period Beginning:

9/1/06

Ending:

8/31/07

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	25		1961	\$ 140,758	\$	30	\$	\$	\$ 140,758	4
5	49		1969	326,818		15-33			326,818	5
6										6
7										7
8										8
	Improvement Type**									
9	PATIO COVER		1971	1,500		20			1,500	9
10	LAUNDRY REMODELING		1974	6,242		20			6,242	10
11	GARAGE		1976	2,235		20			2,235	11
12	GARAGE WIRING & DOOR CLOSURE		1980	1,021		10--15			1,021	12
13	FIREPROOF I-BEAM		1981	1,039		10			1,039	13
14	PATIENT REC ROOM		1982	127,130	4,237	30	4,237		105,238	14
15	CEILINGS		1983	13,650		15			13,650	15
16	PORCH & ACCESS		1984	7,954		10--20			7,954	16
17	SOUTH PORCH, ELEC DOOR		1984	394		10			394	17
18	CARPET ALL PORCHES		1984	1,400		10			1,400	18
19	BASEMENT REPAIR		1985	2,947		10			2,947	19
20	ACTIVATORS/RADIATORS		1986	585		10			585	20
21	HAND RAIL, RAMP, CARPET		1986	1,137		10			1,137	21
22	HEAT CONTROL VALVES		1986	851		10			851	22
23	GAZEBO		1987	1,575		10			1,575	23
24	AIR CONDITIONING		1987	1,048		10			1,048	24
25	REROOFING/PORCH REPAIR		1988	14,500		10			14,500	25
26	DUCTS FOR KITCH EQUIPMENT		1989	1,910	96	20	96		1,736	26
27	BRICK FOR BUILDING		1989	8,500	340	25	340		6,163	27
28	OVERHANG ON BUILDING		1989	3,810		15			3,810	28
29	GENERATOR BUILDING		1992	7,527	334	15	334		7,527	29
30	CARPET		1993	581		10			581	30
31	NURSING ROOF REPAIR		1993	4,840	322	15	322		4,492	31
32	BUILDING ADDITION		1993	203,556	6,429	10--30	6,429		101,244	32
33	CARPETING		1996	352		10			352	33
34	FOLDING DOORS		1996	2,090	140	15	140		1,589	34
35	SCREEN DOORS		1996	540	36	15	36		405	35
36	FOLDING DOORS		1996	6,688	446	15	446		4942	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

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNTY

0005785

Report Period Beginning:

9/1/06

Ending:

8/31/07

XI. OWNERSHIP COSTS (continued)

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

1	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 DOORS	1997	\$ 828	\$ 55	15	\$ 55	\$	\$ 579	37
38 SPRINKLER SYSTEM	1997	8,432	281	30	281		2,951	38
39 FLOORING	1998	991		7			991	39
40 DOOR ALARM SYSTEM	2001	25,906	2,591	10	2,591		15,112	40
41 SHINGLES	2003	15,500	1,550	10	1,550		6,846	41
42 ROOFING LABOR	2003	15,000	1,500	10	1,500		6,000	42
43 ALARM FOR NEW DOORS	2003	3,417	342	10	342		1,452	43
44 FINAL ROOF PAYMENT	2003	15,274	1,528	10	1,528		5,728	44
45 DOOR LOCKS	2004	8,234	1,646	5	1,646		4,940	45
46 GARAGE	2004	36,457	1,823	20	1,823		5,317	46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 1,023,217	\$ 23,696		\$ 23,696	\$	\$ 813,649	70

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

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNTY

0005785

Report Period Beginning:

9/1/06

Ending:

8/31/07

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		\$ 1,023,217	\$ 23,696		\$ 23,696	\$	\$ 813,649	1
2	DRIVEWAY	1961	8,794		20			8,794	2
3	DRIVEWAY	1965	2,538		20			2,538	3
4	DRIVEWAY	1969	1,213		20			1,213	4
5	CONCRETE	1970	187		10			187	5
6	BLACKTOP	1975	648		10			648	6
7	ROCK GARAGE DRIVE	1976	85		10			85	7
8	FENCE	1977	1,740		10			1,740	8
9	BLACKTOP FROM DRIVE	1979	11,375		7			11,375	9
10	SEAL DRIVEWAY	1979	1,050		5			1,050	10
11	BLACKTOP BACK DRIVEWAY	1980	5,335		7			5,335	11
12	SEAL BACK DRIVEWAY	1980	660		5			660	12
13	LANDSCAPE ALONG DRIVE	1982	400		5			400	13
14	TREES SHRUBS	1983	466		10			466	14
15	TREES SHRUBS	1984	2,081		10			2,081	15
16	ASPHALT SEAL PARKING LOT	1984	10,950		10			10,950	16
17	SHRUBS FLOWERS	1985	933		10			933	17
18	FLOWERS WOOD CHIPS	1986	125		10			125	18
19	SIDEWALK FOR GAZEBO	1987	3,465		10			3,465	19
20	SHRUBS	1988	600		10			600	20
21	SHRUBBERY	1991	965		10			965	21
22	LANDSCAPING NEW ADDN	1994	1,500		10			1,500	22
23	SHRUBBERY	1994	491		10			491	23
24	SIDEWALK	1994	665		10			665	24
25	CEMENT	1996	403		10			403	25
26	FENCE	1996	8,160		10			8,160	26
27	FENCE	1996	1,148	57	10	57		1,148	27
28	CONCRETE SIDEWALK	1998	1,760	176	10	176		1,555	28
29	ROCK FOR SIDEWALK	1999	6,884	688	10	688		5,965	29
30	ROCK FRONT OF BUILDING	1999	1,770	177	10	177		1,446	30
31	LIGHT POLES-PARKING LOT	1999	6,640	664	10	664		5,644	31
32	BLACKTOP	1999	9,075	908	10	908		7,262	32
33	BLACKTOP	1999	2,925	293	10	293		2,318	33
34	TOTAL (lines 1 thru 33)		\$ 1,118,248	\$ 26,659		\$ 26,659	\$	\$ 903,816	34

**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	Totals from Page 12B, Carried Forward		\$ 1,118,248	\$ 26,659		\$ 26,659	\$	\$ 903,816	1
2	SHRUBBERY	2001	1,443	145	10	145		914	2
3	CANOPY	2001	33,843	3,385	10	3,385		21,434	3
4	CANOPY AND PLANTERS	2001	6,530	653	10	653		3,809	4
5	WINDSOR POLY FENCE	2002	1,319	132	10	132		627	5
6	TREE SHRUBS	2002	335	33	10	33		159	6
7	SIDEWALK FOR N AND S EXITS	2003	2,197	219	10	219		970	7
8	SHRUBS	2003	73	7	10	7		30	8
9	DIRT/SAND FOR SIDEWALK	2002	525	52	10	52		249	9
10	RIVER CITY FENCING	2004	1,034	130	8	130		388	10
11	OVERLAY DRIVEWAY	2004	4,114	412	10	412		1,166	11
12	CONCRETE SIDEWALK	2005	1,870	187	10	187		405	12
13	SIDEWALK LIGHTS	2005	11,662	1,167	10	1,167		1,944	13
14	SIDEWALK LIGHTING	2005	4,636	464	10	464		889	14
15	NEW BACK PARKING LOT	2005	3,407	227	15	227		416	15
16	SIDEWALK	2005	6,594	440	15	440		806	16
17	FENCE	2006	1,986	398	5	398		530	17
18	DECK AND CONCRETE	2006	14,707	1,471	10	1,471		2,206	18
19	BLACKTOP NEW BACK PARKING LOT	2006	5,586	372	15	372		372	19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,220,109	\$ 36,553		\$ 36,553	\$	\$ 941,130	34

**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	\$ 409,148	\$ 42,260	\$ 42,260	\$	3--20	\$ 270,651	71
72	Current Year Purchases	40,498	2,863	2,863		3--15	2,863	72
73	Fully Depreciated Assets	600,118					600,118	73
74								74
75	TOTALS	\$ 1,049,764	\$ 45,123	\$ 45,123	\$		\$ 873,632	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	SNOW PLOW	FORD BLAZER	1985	\$ 1,450	\$	\$	\$	8	\$ 1,450	76
77	MAINTENANCE	4X4 TRUCK	2003	2,000	400	400		5	1,633	77
78	PATIENT CARE	1999 FORD DIAMOND	2004	15,800	1,580	1,580			4,740	78
79										79
80	TOTALS			\$ 19,250	\$ 1,980	\$ 1,980	\$		\$ 7,823	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)	\$ 2,300,600	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 83,656	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 83,656	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,822,585	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	FILL DIRT FOR FENCE	\$ 2,265	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 2,265	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 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								6
7	TOTAL				\$			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: \$ _____ 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					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. _____ /2008 \$ _____

13. _____ /2009 \$ _____

14. _____ /2010 \$ _____

* 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>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.

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		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							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			\$		\$	\$		\$	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.

Facility Name & ID Number **RESTHAVE HOME-WHITESIDE COUNTY**

0005785

Report Period Beginning: **9/1/06**

Ending:

8/31/07

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **8/31/07**

(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	\$ 150,833	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	73,773		3
4	Supply Inventory (priced at <u>Low cost/market</u>)	11,730		4
5	Short-Term Investments			5
6	Prepaid Insurance	8,089		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>INTEREST RECEIVABLE</u>	605		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 245,030	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	2,633,567		12
13	Land	11,477		13
14	Buildings, at Historical Cost	1,023,217		14
15	Leasehold Improvements, at Historical Cost	199,157		15
16	Equipment, at Historical Cost	1,069,014		16
17	Accumulated Depreciation (book methods)	(1,822,585)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,113,847	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,358,877	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 25,795	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	31,167		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>SEE ATTACHED STATEMENT</u>	42,443		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 99,405	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 99,405	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,259,472	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,358,877	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,161,753	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,161,753	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	97,719	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)	\$ 97,719	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)	\$ 3,259,472	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNTY

0005785

Report Period Beginning: 9/1/06

Ending:

8/31/07

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	\$ 2,460,790	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,460,790	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	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	22,792	13
14	Non-Patient Meals	5,456	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 28,248	23
D. Non-Operating Revenue			
24	Contributions	29,411	24
25	Interest and Other Investment Income***	91,237	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 120,648	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,609,686	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	728,176	31
32	Health Care	1,263,517	32
33	General Administration	499,113	33
B. Capital Expense			
34	Ownership	(26,580)	34
C. Ancillary Expense			
35	Special Cost Centers	47,741	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,511,967	40
41	Income before Income Taxes (line 30 minus line 40)**	97,719	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 97,719	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **RESTHAVE HOME-WHITESIDE COUNTY**

0005785

Report Period Beginning:

9/1/06

Ending:

8/31/07

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	2,000	2,220	\$ 60,389	\$ 27.20	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,355	10,910	221,490	20.30	3
4	Licensed Practical Nurses	9,244	9,869	184,738	18.72	4
5	CNAs & Orderlies	39,538	41,618	442,602	10.63	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,067	3,067	36,436	11.88	8
9	Activity Director	1,631	1,776	19,442	10.95	9
10	Activity Assistants	7,865	8,171	78,503	9.61	10
11	Social Service Workers	3,040	3,121	42,525	13.63	11
12	Dietician					12
13	Food Service Supervisor	1,845	2,088	34,726	16.63	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,365	18,764	169,519	9.03	15
16	Dishwashers					16
17	Maintenance Workers	4,354	4,718	57,304	12.15	17
18	Housekeepers	8,921	10,048	99,655	9.92	18
19	Laundry	4,703	5,140	53,156	10.34	19
20	Administrator	2,049	2,220	77,019	34.69	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,242	4,631	64,473	13.92	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					31
32	Other Health Care(specify)					32
33	Other(specify) <u>LNA</u>	2,277	2,490	21,160	8.50	33
34	TOTAL (lines 1 - 33)	122,496	130,851	\$ 1,663,137 *	\$ 12.71	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	47	\$ 2,150	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	48	1,200	10-3	39
40	Physical Therapy Consultant	31	1,983	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	16	1,400	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	141	\$ 6,733		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses				50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	928	20,356	10-3	52
53	TOTAL (lines 50 - 52)	928	\$ 20,356		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
JAMES HUBER	ADMINISTRATOR	0	\$ 77,019	Workers' Compensation Insurance	\$ 45,076	IDPH License Fee	\$	
				Unemployment Compensation Insurance		Advertising: Employee Recruitment		
				FICA Taxes	139,315	Health Care Worker Background Check	305	
				Employee Health Insurance	84,797	(Indicate # of checks performed)		
				Employee Meals		IHCA DUES	4,425	
				Illinois Municipal Retirement Fund (IMRF)*		HPSI DUES	33	
				EMPLOYEE PHYSICALS	1,247	IHCA DUES SPENT ON LOBBING	(1,297)	
				401 (K)	2,279	OTHER ADVERTISING DUES SUBS	3,511	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 77,019	TOTAL (agree to Schedule V, line 22, col.8)		\$ 4,301		
B. Administrative - Other							Less: Public Relations Expense ()	
Description			Amount				Non-allowable advertising (2,676)	
			\$				Yellow page advertising ()	
							TOTAL (agree to Sch. V, line 20, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				\$ 4,301	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
CLIFTON GUNDERSON LLP	ACCOUNTING		9,000				Out-of-State Travel	\$
DUANE MORRIS LLP	LEGAL		2,880					
							In-State Travel	
							MILEAGE REIMBURSE-ERRANDS	622
							NURSING/PATIENTS	302
							RESIDENT ACTIVITIES	98
							Seminar Expense	
							TRAVEL/MEETING/CONFERENCES	4,130
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 11,880	TOTAL		\$	Entertainment Expense ()	
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 5,151

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNTY

0005785

Report Period Beginning: 9/1/06

Ending: 8/31/07

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. Illinois Healthcare Association- \$4425
- (3) Did the nursing home make political contributions or payments to a political action organization? YES-Indirectly If YES, have these costs been properly adjusted out of the cost report? YES-IHCA Lobbying
- (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? _____
- (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? 7 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 20,276 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. _____
- (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. \$ 26,828
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, 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. \$ 5,456
- (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. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 50%
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? No personal use of vehicles
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. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: CLIFTON GUNDERSON, 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? YES If no, please explain. _____
- (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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

RESTHAVE HOME OF WHITESIDE COUNTY, ILLINOIS
EXPENSES RELATING TO WASTE REMOVAL
SCHEDULE V, LINE 7, COLUMN 3
9/1/06-9/1/07

SCHEDULE V, LINE 7, COLUMN 3 INCLUDES WASTE REMOVAL COSTS OF
\$1,846, WHICH IS BROKEN DOWN AS FOLLOWS:

DATE	AMOUNT	PAYEE
9/8/2006	130	MORING DISPOSAL, INC.
9/29/2006	143	MORING DISPOSAL, INC.
11/16/2006	143	MORING DISPOSAL, INC.
12/7/2006	143	MORING DISPOSAL, INC.
12/28/2006	143	MORING DISPOSAL, INC.
2/1/2007	143	MORING DISPOSAL, INC.
3/6/2007	143	MORING DISPOSAL, INC.
4/5/2007	143	MORING DISPOSAL, INC.
5/3/2007	143	MORING DISPOSAL, INC.
5/25/2007	143	MORING DISPOSAL, INC.
6/26/2007	143	MORING DISPOSAL, INC.
7/31/2007	143	MORING DISPOSAL, INC.
8/29/2007	143	MORING DISPOSAL, INC.
	<u>\$ 1,846</u>	

RESTHAVE HOME OF WHITESIDE COUNTY, ILLINOIS
OTHER EXPENSES
SCHEDULE V - COST CENTER EXP - LINE 36
9/1/06-8/31/07

UNREALIZED GAIN ON INVESTMENT	(120,296)
REALIZED LOSS ON INVESTMENT	7,209
INVESTMENT EXPENSE	<u>2,851</u>
	(110,236)

LINE 36, SCHEDULE V OF THE COST REPORT INITIALLY REPORTS CAPITAL EXPENSE OF \$(110,236). THIS AMOUNT REPRESENTS INVESTMENT EXPENSES AND LOSSES/ GAINS FOR THE CURRENT FISCAL YEAR AND IS COMPLETELY ADJUSTED OUT ON LINE 10 OF SCHEDULE VI-ADJUSTMENT DETAIL. THEREFORE, ALL INTEREST INCOME OF \$91,237 IS INCLUDED ON SCHEDULE XVII-INCOME STATEMENT.

RESTHAVE HOME OF WHITESIDE COUNTY, ILLINOIS
OTHER LIABILITIES
SCHEDULE XV, LINE 36
9/1/06-8/31/07

LICENSED BED FEE	6,762
OTHER PAYROLL DEDUCTIONS W/H	13,119
VACATION PAYABLE	20,097
HFS AUDIT LIABILITY	<u>2,465</u>
	42,443

RESTHAVE HOME OF WHITESIDE COUNTY, ILLINOIS
EXPENSES RELATING TO NURSE AID TRAINING PROGRAMS
SCHEDULE XIII
9/1/06-8/31/07

RESTHAVE HOME OF WHITESIDE COUNTY DOES NOT TRAIN NURSES'
AIDES. THE AIDES ARE RESPONSIBLE FOR HAVING ALL TRAINING
COMPLETED PRIOR TO BEING HIRED.