



Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNTY

# 0005785 Report Period Beginning: 9/1/07 Ending: 8/31/08

**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	17,934	3
4		Intermediate/DD			4
5	25	Sheltered Care (SC)	25	9,150	5
6		ICF/DD 16 or Less			6
7	74	TOTALS	74	27,084	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF	7,811	9,818		17,629
11	ICF/DD				11
12	SC		7,857		7,857
13	DD 16 OR LESS				13
14	TOTALS	7,811	17,675		25,486

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.10%

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: 8/31/08 Fiscal Year: 8/31/08

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

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNT # 0005785 Report Period Beginning: 9/1/07 Ending: 8/31/08

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	216,269	28,556	5,629	250,454		250,454		250,454		1
2	Food Purchase		167,359		167,359		167,359	(6,149)	161,210		2
3	Housekeeping	105,202	16,594	294	122,090		122,090		122,090		3
4	Laundry	55,362	7,823	7,934	71,119		71,119		71,119		4
5	Heat and Other Utilities			71,716	71,716		71,716		71,716		5
6	Maintenance	51,161	9,500	18,891	79,552		79,552		79,552		6
7	Other (specify):*			1,830	1,830		1,830		1,830		7
8	<b>TOTAL General Services</b>	427,994	229,832	106,294	764,120		764,120	(6,149)	757,971		8
<b>B. Health Care and Programs</b>											
9	Medical Director										9
10	Nursing and Medical Records	966,347	67,729	63,791	1,097,867		1,097,867		1,097,867		10
10a	Therapy	33,128		2,438	35,566		35,566		35,566		10a
11	Activities	103,396	6,332	10,049	119,777		119,777	(5,594)	114,183		11
12	Social Services	43,181	1,729	2,226	47,136		47,136		47,136		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,146,052	75,790	78,504	1,300,346		1,300,346	(5,594)	1,294,752		16
<b>C. General Administration</b>											
17	Administrative	88,486			88,486		88,486		88,486		17
18	Directors Fees										18
19	Professional Services			10,213	10,213		10,213		10,213		19
20	Dues, Fees, Subscriptions & Promotions			5,154	5,154		5,154	(1,466)	3,688		20
21	Clerical & General Office Expenses	52,484	13,271	17,674	83,429		83,429	(3,490)	79,939		21
22	Employee Benefits & Payroll Taxes			267,288	267,288		267,288		267,288		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,743	4,743		4,743		4,743		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			37,694	37,694		37,694		37,694		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	140,970	13,271	342,766	497,007		497,007	(4,956)	492,051		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,715,016	318,893	527,564	2,561,473		2,561,473	(16,699)	2,544,774		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
<b>30</b>	<b>D. Ownership</b>										
	Depreciation			75,165	75,165	75,165		75,165			30
<b>31</b>	Amortization of Pre-Op. & Org.										31
<b>32</b>	Interest										32
<b>33</b>	Real Estate Taxes										33
<b>34</b>	Rent-Facility & Grounds										34
<b>35</b>	Rent-Equipment & Vehicles										35
<b>36</b>	Other (specify):*			279,045	279,045	279,045	(279,045)				36
<b>37</b>	<b>TOTAL Ownership</b>			354,210	354,210	354,210	(279,045)	75,165			37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
<b>38</b>	Medically Necessary Transportation										38
<b>39</b>	Ancillary Service Centers										39
<b>40</b>	Barber and Beauty Shops			19,769	19,769	19,769		19,769			40
<b>41</b>	Coffee and Gift Shops										41
<b>42</b>	Provider Participation Fee			24,648	24,648	24,648		24,648			42
<b>43</b>	Other (specify):*										43
<b>44</b>	<b>TOTAL Special Cost Centers</b>			44,417	44,417	44,417		44,417			44
<b>45</b>	<b>GRAND TOTAL COST</b>										
	(sum of lines 29, 37 & 44)	1,715,016	318,893	926,191	2,960,100	2,960,100	(295,744)	2,664,356			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	(6,149)	2		4
5 Telephone, TV & Radio in Resident Rooms	(5,594)	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				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 Retainer				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt				24
25 Fund Raising, Advertising and Promotional	(3,490)	21		25
Income Taxes and Illinois Persona				
26 Property Replacement Tax				26
27 CNA Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule	(279,045)	36		29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (294,278)		\$	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) )	\$ (294,278)		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		x			41
42 Laboratory and Radiology					42
43 Prescription Drugs					43
44					44
45 Other-Attach Schedule	x		(1,466)	20	45
46 Other-Attach Schedule					46
47 TOTAL (C): (sum of lines 38-46)			\$ (1,466)		47

RESTHAVE HOME-WHITESIDE COUNTYID# 0005785Report Period Beginning: 9/1/07Ending: 8/31/08Sch. V Line  
Reference

## NON-ALLOWABLE EXPENSES

Amount

1	CABLEVISION	\$	0	21 1
2	IHCA DUES - PORTION FOR LOBBYING		(1,466)	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	<b>Total</b>		(1,466)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNTY

# 0005785 Report Period Beginning:

9/1/07

Ending:

8/31/08

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(6,149)	0	0	0	0	0	0	0	0	0	0	(6,149)	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	<b>TOTAL General Services</b>	<b>(6,149)</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>(6,149)</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	(5,594)	0	0	0	0	0	0	0	0	0	0	(5,594)	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>(5,594)</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>(5,594)</b>	<b>16</b>
	<b>C. General Administration</b>													
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	(1,466)	0	0	0	0	0	0	0	0	0	0	(1,466)	20
21	Clerical & General Office Expenses	(3,490)	0	0	0	0	0	0	0	0	0	0	(3,490)	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	<b>TOTAL General Administration</b>	<b>(4,956)</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>(4,956)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(16,699)</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>(16,699)</b>	<b>29</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
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.

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: 9/1/07 Ending: 8/31/08

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	<b>TOTALS</b>				\$	\$		\$	25

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

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

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense
		YES	NO				Original	Balance			
	<b>A. Directly Facility Related</b>										
	<b>Long-Term</b>										
1	NONE						\$	\$			\$
2											
3											
4											
5											
	<b>Working Capital</b>										
6											
7											
8											
9	<b>TOTAL Facility Related</b>						\$	\$			\$
	<b>B. Non-Facility Related*</b>										
10											
11											
12											
13											
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$
15	<b>TOTALS (line 9+line14)</b>						\$	\$			\$

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.)

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)**

**B. Real Estate Taxes**

<p><b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																							
1. Real Estate Tax accrual used on 2007 report.		\$	N/A																				
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.)		\$																					
3. Under or (over) accrual (line 2 minus line 1).		\$	#VALUE!																				
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$																					
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>		\$																					
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>		\$																					
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6		\$	#VALUE!																				
Real Estate Tax History:																							
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2003</td><td>8</td></tr> <tr><td>2004</td><td>9</td></tr> <tr><td>2005</td><td>10</td></tr> <tr><td>2006</td><td>11</td></tr> <tr><td>2007</td><td>12</td></tr> </table>	2003	8	2004	9	2005	10	2006	11	2007	12	<table border="1"> <tr><th colspan="2">FOR BHF USE ONLY</th></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2007 \$</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5 \$</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6 \$</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION\$</td></tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2007 \$	14	PLUS APPEAL COST FROM LINE 5 \$	15	LESS REFUND FROM LINE 6 \$	16	AMOUNT TO USE FOR RATE CALCULATION\$
2003	8																						
2004	9																						
2005	10																						
2006	11																						
2007	12																						
FOR BHF USE ONLY																							
13	FROM R. E. TAX STATEMENT FOR 2007 \$																						
14	PLUS APPEAL COST FROM LINE 5 \$																						
15	LESS REFUND FROM LINE 6 \$																						
16	AMOUNT TO USE FOR RATE CALCULATION\$																						

**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.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

**2007 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME RESTHAVE HOME-WHITESIDE COUNTY COUNTY WHITESIDE

FACILITY IDPH LICENSE NUMBER 0005785

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE ( ) \_\_\_\_\_ FAX #: ( ) \_\_\_\_\_

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ _____	\$ _____

**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?        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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

**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: 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 &amp; 1964</u>	<u>\$ 10,977</u>	1
2	<u>CREEK STREET PROPERTY</u>	<u>2,500</u>	<u>2003</u>	<u>500</u>	2
3	<b>TOTALS</b>	<u>357,335</u>		<u>\$ 11,477</u>	3

## XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		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
		<b>Improvement Type**</b>									
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	4,238	30	4,238		109,476	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	95	20	95		1,831	26
27		BRICK FOR BUILDING		1989	8,500	340	25	340		6,503	27
28		OVERHANG ON BUILDING		1989	3,810		15			3,810	28
29		GENERATOR BUILDING		1992	7,527		15			7,527	29
30		CARPET		1993	581		10			581	30
31		NURSING ROOF REPAIR		1993	4,840	323	15	323		4,815	31
32		BUILDING ADDITION		1993	203,556	6,425	10--30	6,425		107,669	32
33		CARPETING		1996	352		10			352	33
34		FOLDING DOORS		1996	2,090	139	15	139		1,728	34
35		SCREEN DOORS		1996	540	36	15	36		441	35
36		FOLDING DOORS		1996	6,688	446	15	446		5,388	36

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

See Page 12A, Line 70 for total

\*\*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		
37 DOORS	1997	\$ 828	\$ 55	15	\$ 55		\$ 634	37	37
38 SPRINKLER SYSTEM	1997	8,432	281	30	281		3,232	38	38
39 FLOORING	1998	991		7			991	39	39
40 DOOR ALARM SYSTEM	2001	25,906	2,590	10	2,590		17,702	40	40
41 SHINGLES	2003	15,500	1,550	10	1,550		8,396	41	41
42 ROOFING LABOR	2003	15,000	1,500	10	1,500		7,500	42	42
43 ALARM FOR NEW DOORS	2003	3,417	342	10	342		1,794	43	43
44 FINAL ROOF PAYMENT	2003	15,274	1,527	10	1,527		7,255	44	44
45 DOOR LOCKS	2004	8,234	1,647	5	1,647		6,587	45	45
46 GARAGE	2004	36,457	1,823	20	1,823		7,140	46	46
47								47	47
48								48	48
49								49	49
50								50	50
51								51	51
52								52	52
53								53	53
54								54	54
55								55	55
56								56	56
57								57	57
58								58	58
59								59	59
60								60	60
61								61	61
62								62	62
63								63	63
64								64	64
65								65	65
66								66	66
67								67	67
68								68	68
69								69	69
70 TOTAL (lines 4 thru 69)		\$ 1,023,217	\$ 23,357		\$ 23,357		\$ 837,006	70	70

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

Facility Name &amp; ID Number RESTHAVE HOME-WHITESIDE COUNTY

# 0005785

Report Period Beginning:

9/1/07

Ending:

8/31/08

## 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	10
	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	\$ 23,357		\$ 23,357		\$ 837,006	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		10			1,148	27
28	CONCRETE SIDEWALK	1998	1,760	176	10	176		1,731	28
29	ROCK FOR SIDEWALK	1999	6,884	688	10	688		6,653	29
30	ROCK FRONT OF BUILDING	1999	1,770	177	10	177		1,623	30
31	LIGHT POLES-PARKING LOT	1999	6,640	664	10	664		6,308	31
32	BLACKTOP	1999	9,075	907	10	907		8,169	32
33	BLACKTOP	1999	2,925	292	10	292		2,610	33
34	TOTAL (lines 1 thru 33)		\$ 1,118,248	\$ 26,261		\$ 26,261		\$ 930,077	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	10
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>	\$ 1,118,248	\$ 26,261		\$ 26,261		\$ 930,077		1
2	SHRUBBERY	2001 1,443	144	10	144		1,058		2
3	CANOPY	2001 33,843	3,384	10	3,384		24,818		3
4	CANOPY AND PLANTERS	2001 6,530	653	10	653		4,462		4
5	WINDSOR POLY FENCE	2002 1,319	132	10	132		759		5
6	TREE SHRUBS	2002 335	34	10	34		193		6
7	SIDEWALK FOR N AND S EXITS	2003 2,197	220	10	220		1,190		7
8	SHRUBS	2003 73	8	10	8		38		8
9	DIRT/SAND FOR SIDEWALK	2002 525	53	10	53		302		9
10	RIVER CITY FENCING	2004 1,034	129	8	129		517		10
11	OVERLAY DRIVEWAY	2004 4,114	411	10	411		1,577		11
12	CONCRETE SIDEWALK	2005 1,870	187	10	187		592		12
13	SIDEWALK LIGHTS	2005 11,662	1,166	10	1,166		3,110		13
14	SIDEWALK LIGHTING	2005 4,636	463	10	463		1,352		14
15	NEW BACK PARKING LOT	2005 3,407	228	15	228		644		15
16	SIDEWALK	2005 6,594	440	15	440		1,246		16
17	FENCE	2006 1,986	397	5	397		927		17
18	DECK AND CONCRETE	2006 14,707	1,471	10	1,471		3,677		18
19	BLACKTOP NEW BACK PARKING LOT	2006 5,586	373	15	373		745		19
20	SIDEWALK	2008 10,169		15					20
21	SEVEN LAMP POSTS	2008 4,441	185	8	185		185		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	<b>TOTAL (lines 1 thru 33)</b>	\$ 1,234,719	\$ 36,339		\$ 36,339		\$ 977,469		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	\$ 362,911	\$ 35,569	\$ 35,569		3-20	\$ 222,348	71
72	Current Year Purchases	23,012	1,310	1,310		3-10	1,310	72
73	Fully Depreciated Assets	686,853					686,853	73
74								74
75	TOTALS	\$ 1,072,776	\$ 36,879	\$ 36,879			\$ 910,511	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	367	367		5	2,000	77
78	PATIENT CARE	1999 FORD DIAMOND	2004	15,800	1,580	1,580		10	6,320	78
79										79
80	TOTALS			\$ 19,250	\$ 1,947	\$ 1,947			\$ 9,770	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)	\$ 2,338,222	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 75,165	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 75,165	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)	\$ 1,897,750	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	<b>TOTAL</b>				\$			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	<b>TOTAL</b>		\$	\$	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. \_\_\_\_\_/2009 \$ \_\_\_\_\_

13. \_\_\_\_\_/2010 \$ \_\_\_\_\_

14. \_\_\_\_\_/2011 \$ \_\_\_\_\_

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

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

**A. TYPE OF TRAINING PROGRAM (If 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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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			
	1	2	3	4
	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)	
<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.

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

1	Service	Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or) Allocated	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5					
					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	Other (specify):									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.

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	\$ 201,380	\$ 1
2	Cash-Patient Deposits		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	85,836	3
4	Supply Inventory (priced at <u>low cost/market</u> )	11,730	4
5	Short-Term Investments		5
6	Prepaid Insurance	12,079	6
7	Other Prepaid Expenses		7
8	Accounts Receivable (owners or related parties)		8
9	Other(specify): <u>Interest Receivable</u>	605	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 311,630	\$ 10
<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable		11
12	Long-Term Investments	2,491,874	12
13	Land	11,477	13
14	Buildings, at Historical Cost	1,023,217	14
15	Leasehold Improvements, at Historical Cos	213,766	15
16	Equipment, at Historical Cost	1,092,023	16
17	Accumulated Depreciation (book methods)	(1,897,750)	17
18	Deferred Charges		18
19	Organization & Pre-Operating Costs		19
20	Accumulated Amortization - Organization & Pre-Operating Costs		20
21	Restricted Funds		21
22	Other Long-Term Assets (specify):		22
23	Other(specify):		23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 2,934,607	\$ 24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 3,246,237	\$ 25

	1	2	
	Operating	After Consolidation*	
<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 33,280	\$ 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
<b>Other Current Liabilities(specify):</b>			
36	<u>SEE ATTACHED STATEMENT</u>	47,862	36
37			37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 112,309	\$ 38
<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable		39
40	Mortgage Payable		40
41	Bonds Payable		41
42	Deferred Compensation		42
<b>Other Long-Term Liabilities(specify):</b>			
43			43
44			44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$ 45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 112,309	\$ 46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 3,133,928	\$ 47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 3,246,237	\$ 48

\*(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>3,259,472</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>3,259,472</b>	<b>6</b>
<b>A. Additions (deductions):</b>			
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(125,544)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(125,544)</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>3,133,928</b>	<b>24</b> *

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

**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	\$ 2,695,070	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,695,070	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	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	21,389	13
14	Non-Patient Meals	6,149	14
15	Telephone, Television and Radic		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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 27,538	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	24,254	24
25	Interest and Other Investment Income***	87,694	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 111,948	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,834,556	30

2

Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	764,120	31
32	Health Care	1,300,346	32
33	General Administration	497,007	33
<b>B. Capital Expense</b>			
34	Ownership	354,210	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	44,417	35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,960,100	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(125,544)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (125,544)	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.

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,817	2,214	\$ 62,987	\$ 28.45	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,090	10,374	214,737	20.70	3
4	Licensed Practical Nurses	9,068	11,146	203,573	18.26	4
5	CNAs & Orderlies	38,488	43,486	462,605	10.64	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,731	2,731	33,697	12.34	8
9	Activity Director	1,548	1,787	19,837	11.10	9
10	Activity Assistants	7,363	8,085	83,559	10.34	10
11	Social Service Workers	2,763	3,044	42,680	14.02	11
12	Dietician					12
13	Food Service Supervisor	1,666	2,084	34,672	16.64	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,605	18,819	181,542	9.65	15
16	Dishwashers					16
17	Maintenance Workers	4,365	4,746	51,160	10.78	17
18	Housekeepers	9,039	10,260	105,203	10.25	18
19	Laundry	4,545	5,425	55,362	10.20	19
20	Administrator	1,925	2,159	88,486	40.98	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,743	4,255	52,472	12.33	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>	2,221	2,570	22,444	8.73	33
34	TOTAL (lines 1 - 33)	116,977	133,185	\$ 1,715,016 *	\$ 12.88	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	48	\$ 2,686	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	55	1,375	10-3	39
40	Physical Therapy Consultant	38	2,438	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	1,621	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	157	\$ 8,120		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	572	13,146	10-3	52
53	TOTAL (lines 50 - 52)	572	\$ 13,146		53

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	\$ 88,486	Workers' Compensation Insurance	\$ 40,259	IDPH License Fee	\$	
				Unemployment Compensation Insurance		Advertising: Employee Recruitment		
				FICA Taxes	134,775	Health Care Worker Background Check	703	
				Employee Health Insurance	87,820	(Indicate # of checks performed _____)		
				Employee Meals		AANAC	110	
				Illinois Municipal Retirement Fund (IMRF)*		IHCA DUES	4,085	
				EMPLOYEE PHYSICALS	2,337	HPSI DUES	21	
				401 (k)	2,097	IHCA DUES SPENT ON LOBBING	(1,466)	
						NFPA International	150	
						OTHER ADVERTISING DUES	85	
						Less: Public Relations Expense	( )	
						Non-allowable advertising	( )	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
\$ 88,486				\$ 267,288		\$ 3,688		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description	Amount			Description	Line #	Amount	Description	Amount
	\$					\$	Out-of-State Travel	\$
							In-State Travel	
							MILEAGE REIMBURSEMENT-ERRANDS	688
							NURSING/PATIENTS	363
							RESIDENT ACTIVITIES	42
							Seminar Expense	
							TRAVEL/MEETING/CONFERENCES	3,650
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	
\$				\$			\$ 4,743	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)								
\$ 10,213								

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name &amp; ID Number RESTHAVE HOME-WHITESIDE COUNTY

# 0005785

Report Period Beginning:

9/1/07

Ending:

8/31/08

**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 - \$4,085
- (3) Did the nursing home make political contributions or payments to a political 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. \$ 23,129 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 \_\_\_\_\_ NO X
- (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. \$ 24,648  
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 benefit on Schedule V. \$ 0 Has any meal income been offset against related costs? YES Indicate the amount. \$ 6,149
- (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? 40%  
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  
9/1/07 - 8/31/08

SCHEDULE V, LINE 7, COLUMN 3 INCLUDES WASTE REMOVAL COSTS OF  
\$1,830, WHICH IS BROKEN DOWN AS FOLLOWS:

<u>DATE</u>	<u>AMOUNT</u>	<u>PAYEE</u>
9/26/2007	143.00	MORING DISPOSAL, INC
10/26/2007	143.00	MORING DISPOSAL, INC
12/5/2007	143.00	MORING DISPOSAL, INC
1/8/2008	143.00	MORING DISPOSAL, INC
2/1/2008	157.30	MORING DISPOSAL, INC
2/27/2008	157.30	MORING DISPOSAL, INC
3/28/2008	157.30	MORING DISPOSAL, INC
4/29/2008	157.30	MORING DISPOSAL, INC
6/4/2008	157.30	MORING DISPOSAL, INC
6/24/2008	157.30	MORING DISPOSAL, INC
7/30/2008	157.30	MORING DISPOSAL, INC
8/27/2008	157.30	MORING DISPOSAL, INC
	<u>\$ 1,830.40</u>	

RESTHAVE HOME OF WHITESIDE COUNTY, ILLINOIS  
OTHER EXPENSES  
SCHEDULE V - COST CENTER EXP - LINE 36  
9/1/07 - 8/31/08

UNREALIZED LOSS ON INVESTMENT	143,529
REALIZED LOSS ON INVESTMENT	123,132
INVESTMENT EXPENSE	<u>12,384</u>
	279,045

LINE 36, SCHEDULE V OF THE COST REPORT INITIALLY REPORTS  
CAPITAL EXPENSE OF \$279,045  
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 \$87,694 IS INCLUDED ON  
SCHEDULE XVII - INCOME STATEMENT.

RESTHAVE HOME OF WHITESIDE COUNTY, ILLINOIS  
OTHER LIABILITIES  
SCHEDULE XV, LINE 36  
9/1/07 - 8/31/08

OTHER PAYROLL DEDUCTIONS W/H	3,787
VACATION PAYABLE	44,075
	<hr/>
	47,862



RESTHAVE HOME OF WHITESIDE COUNTY, ILLINOIS  
EXPENSES RELATING TO NURSE AID TRAINING PROGRAMS  
SCHEDULE XIII  
9/1/07 - 8/31/08

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