		FOR BHF USE					

LL1

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0005785

Facility Name: RESTHAVE HOME-WHITESIDE COUNTY

Address: 408 MAPLE AVENUE (Number) MORRISON (City) 61270 (Zip Code)

County: WHITESIDE

Telephone Number: (815) 772-4021 **Fax #** (815) 722-4583

HFS ID Number:

Date of Initial License for Current Owners: 05/22/1969

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501©(3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: JAMES HUBER **Telephone Number:** (815) 772-4021
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 09/01/09 to 08/31/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) JAMES HUBER
(Title) ADMINISTRATOR

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) TODD ETHERIDGE, CPA
(Firm Name & Address) CLIFTON GUNDERSON, LLP
P.O. BOX 368, DIXON, IL 61021
(Telephone) (815) 284-2285 Fax # (815) 284-9265

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNTY # 0005785 Report Period Beginning: 09/01/09 Ending: 08/31/10

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	4,915	11,642		16,557	10
11	ICF/DD					11
12	SC		8,001		8,001	12
13	DD 16 OR LESS					13
14	TOTALS	4,915	19,643		24,558	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.92%

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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04/31/1969

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

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

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

Tax Year: 08/31/10 Fiscal Year: 08/31/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNTY # 0005785 Report Period Beginning: 09/01/09 Ending: 08/31/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	234,950	28,881	11,082	274,913		274,913		274,913			1
2	Food Purchase		181,807		181,807		181,807	(5,417)	176,390			2
3	Housekeeping	114,843	28,403	724	143,970		143,970		143,970			3
4	Laundry	44,630	10,117	3,745	58,492		58,492		58,492			4
5	Heat and Other Utilities			71,198	71,198		71,198		71,198			5
6	Maintenance	51,730	6,856	36,537	95,123		95,123		95,123			6
7	Other (specify):*			2,575	2,575		2,575		2,575			7
8	TOTAL General Services	446,153	256,064	125,861	828,078		828,078	(5,417)	822,661			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,017,944	64,792	20,210	1,102,946		1,102,946		1,102,946			10
10a	Therapy	21,164		2,194	23,358		23,358		23,358			10a
11	Activities	116,619	5,538	9,665	131,822		131,822	(6,481)	125,341			11
12	Social Services	44,717	2,208	888	47,813		47,813		47,813			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,200,444	72,538	32,957	1,305,939		1,305,939	(6,481)	1,299,458			16
	C. General Administration											
17	Administrative	92,067			92,067		92,067		92,067			17
18	Directors Fees											18
19	Professional Services			84,734	84,734		84,734		84,734			19
20	Dues, Fees, Subscriptions & Promotions			5,840	5,840		5,840	(1,276)	4,564			20
21	Clerical & General Office Expenses	48,583	14,306	35,352	98,241		98,241	(3,524)	94,717			21
22	Employee Benefits & Payroll Taxes			303,536	303,536		303,536		303,536			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,132	4,132		4,132		4,132			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			42,158	42,158		42,158		42,158			26
27	Other (specify):*											27
28	TOTAL General Administration	140,650	14,306	475,752	630,708		630,708	(4,800)	625,908			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,787,247	342,908	634,570	2,764,725		2,764,725	(16,698)	2,748,027			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNTY #0005785 Report Period Beginning: 09/01/09 Ending: 08/31/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			88,361	88,361		88,361		88,361			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):*			12,464	12,464		12,464	(12,464)				36
37	**TOTAL Ownership**			100,825	100,825		100,825	(12,464)	88,361			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			18,042	18,042		18,042		18,042			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**			44,870	44,870		44,870		44,870			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,787,247	342,908	780,265	2,910,420		2,910,420	(29,162)	2,881,258			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNTY # 0005785 Report Period Beginning: 09/01/09 Ending: 08/31/10

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,417)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,481)	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 Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(3,524)	21		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	(12,464)	36		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (27,886)		$	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 Amount	2 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
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (27,886)		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 Yes	2 No	3 Amount	4 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		(1,276)	20	45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ (1,276)		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS
RESTHAVE HOME-WHITESIDE COUNTY
ID# 0005785
Report Period Beginning: 09/01/09
Ending: 08/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	IHCA DUES - PORTION FOR LOBBYING	$ (1,276)	20	1
2	INVESTMENT EXPENSES	(12,464)	36	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**	(13,740)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNTY # 0005785 Report Period Beginning: 09/01/09 Ending: 08/31/10

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	(5,417)	0	0	0	0	0	0	0	0	0	0	(5,417)	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**	(5,417)	0	0	0	0	0	0	0	0	0	0	(5,417)	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	(6,481)	0	0	0	0	0	0	0	0	0	0	(6,481)	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**	(6,481)	0	0	0	0	0	0	0	0	0	0	(6,481)	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	(1,276)	0	0	0	0	0	0	0	0	0	0	(1,276)	20
21	Clerical & General Office Expenses	(3,524)	0	0	0	0	0	0	0	0	0	0	(3,524)	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**	(4,800)	0	0	0	0	0	0	0	0	0	0	(4,800)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(16,698)	0	0	0	0	0	0	0	0	0	0	(16,698)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNTY # 0005785 **Report Period Beginning:** 09/01/09 **Ending:** 08/31/10

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):*	(12,464)	0	0	0	0	0	0	0	0	0	0	(12,464)	36
37	**TOTAL Ownership**	(12,464)	0	0	0	0	0	0	0	0	0	0	(12,464)	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
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(29,162)	0	0	0	0	0	0	0	0	0	0	(29,162)	45

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNTY # 0005785 Report Period Beginning: 09/01/09 Ending: 08/31/10

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
N/A						

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	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.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNT # 0005785 Report Period Beginning: 09/01/09 Ending: 08/31/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNTY # 0005785 Report Period Beginning: 09/01/09 Ending: 08/31/10

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 [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNTY # 0005785 Report Period Beginning: 09/01/09 Ending: 08/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	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.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNTY # 0005785 Report Period Beginning: 09/01/09 Ending: 08/31/10

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2005	8
	2006	9
	2007	10
	2008	11
	2009	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

2009 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 2009 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 2009.

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

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 and 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNTY # 0005785 Report Period Beginning: 09/01/09 Ending: 08/31/10

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? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

NONE

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

1. Total Amount Incurred: _____ 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:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY LOCATION	354,835	1958 & 1964	$ 10,977	1
2	CREEK STREET PROPERTY	2,500	2003	500	2
3	TOTALS	357,335		$ 11,477	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNTY # 0005785 Report Period Beginning: 09/01/09 Ending: 08/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 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 TO 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		117,951	14
15	CEILINGS			1983	13,650		15			13,650	15
16	PORCH & ACCESS			1984	7,954		10 TO 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	HADRAIL, RAMP, CARPET			1986	1,137		10			1,137	21
22	HEAT CONTROLS 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 KITCHEN EQUIPMENT			1989	1,910		20			1,910	26
27	BRICK FOR BUILDING			1989	8,500	340	25	340		7,183	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		15			4,840	31
32	BUILDING ADDITION			1993	203,556	6,427	10 TO 20	6,427		120,524	32
33	CARPET ALL PORCHES			1996	352		10			352	33
34	FOLDING DOORS			1996	2,090	140	15	140		2,007	34
35	SCREEN DOORS			1996	540	36	15	36		513	35
36	FOLDING DOORS			1996	6,688	446	15	446		6,280	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNTY # 0005785 Report Period Beginning: 09/01/09 Ending: 08/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	DOORS	1997	$ 828	$ 56	15	$ 56	$	$ 745	37
38	SPRINKLER SYSTEM	1997	8,432	282	30	282		3,795	38
39	FLOORING	1998	991		7			991	39
40	DOOR ALARM SYSTEM	2001	25,906	2,591	10	2,591		22,884	40
41	SHINGLES	2003	15,500	1,550	10	1,550		11,496	41
42	ROOFING LABOR	2003	15,000	1,500	10	1,500		10,500	42
43	ALARM FOR NEW DOOR	2003	3,417	342	10	342		2,477	43
44	FINAL ROOF PAYMENT	2003	15,274	1,527	10	1,527		10,310	44
45	DOOR LOCKS	2004	8,234		5			8,234	45
46	GARAGE	2004	36,457	1,823	20	1,823		10,785	46
47	BASEMENT WATERPROOFING - DRAIN	2010	19,280	536	15	536		536	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)		$ 1,042,497	$ 21,833		$ 21,833	$	$ 881,885	70

SEE ACCOUNTANTS' COMPILATION REPORT

**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: 09/01/09 Ending: 08/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,042,497	$ 21,833		$ 21,833	$	$ 881,885	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					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, FLOWERS	1988	600		10			600	20
21	SHRUBBERY	1991	965		10			965	21
22	LANDSCAPING NEW ADDITION	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		10			1,760	28
29	ROCK FOR SIDEWALK	1999	6,884		10			6,884	29
30	ROCK, FRONT OF BUILDING	1999	1,770		10			1,770	30
31	LIGHT POLES - PARKING LOT	1999	6,640		10			6,640	31
32	BLACKTOP	1999	9,075		10			9,075	32
33	BLACKTOP	1999	2,925	22	10	22		2,925	33
34	TOTAL (lines 1 thru 33)		$ 1,137,528	$ 21,855		$ 21,855	$	$ 976,916	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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: 09/01/09 Ending: 08/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 1,137,528	$ 21,855		$ 21,855	$	$ 976,916	1
2	SHRUBBERY	2001	1,443	144	10	144		1,346	2
3	CANOPY	2001	33,843	3,384	10	3,384		31,586	3
4	CANOPY AND PLANTERS	2001	6,530	653	10	653		5,768	4
5	WINSOR POLY FENCE	2002	1,319	132	10	132		1,023	5
6	TREE SHRUBS	2002	335	34	10	34		260	6
7	SIDEWALK FOR NORTH AND SOUTH EXITS	2003	2,197	219	10	219		1,629	7
8	SHRUBS	2003	73	7	10	7		52	8
9	DIRT/SAND FOR SIDEWALK	2002	525	53	10	53		407	9
10	RIVER CITY FENCING	2004	1,034	129	8	129		775	10
11	OVERLAY DRIVEWAY	2004	4,114	412	10	412		2,400	11
12	CONCRETE SIDEWALK	2005	1,870	187	10	187		966	12
13	SIDEWALK LIGHTS	2005	11,662	1,166	10	1,166		5,442	13
14	SIDEWALK LIGHTING	2005	4,636	463	10	463		2,279	14
15	NEW BACK PARKING LOT	2005	3,407	227	15	227		1,098	15
16	SIDEWALK	2005	6,594	440	15	440		2,125	16
17	FENCE	2006	1,986	397	5	397		1,721	17
18	DECK AND CONCRETE	2006	14,707	1,470	10	1,470		6,618	18
19	BLACKTOP NEW BACK PARKING LOT	2006	5,586	373	15	373		1,490	19
20	SIDEWALK	2008	10,169	678	15	678		1,356	20
21	SEVEN LAMP POST	2008	4,440	555	8	555		1,295	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)		$ 1,253,998	$ 32,978		$ 32,978	$	$ 1,046,552	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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: 09/01/09 Ending: 08/31/10

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	$ 357,263	$ 48,322	$ 48,322	$	3 TO 20	$ 207,792	71
72	Current Year Purchases	105,817	4,164	4,164		3 TO 10	4,164	72
73	Fully Depreciated Assets	745,840					745,840	73
74								74
75	TOTALS	$ 1,208,920	$ 52,486	$ 52,486	$		$ 957,796	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	VEHICLES	FORD BLAZE & 4X4 TRUCK	2003	$ 1,450	$	$	$	5	$ 1,450	76
77	PATIENT CARE	1999 FORD DIAMOND	2004	15,800	1,580	1,580		10	9,480	77
78	MAINTENANCE	TRUCK & PLOW	2009	2,000	267	267		5	267	78
79	MAINTENANCE	98 CHEVY TRUCK	2010	9,000	1,050	1,050		5	1,050	79
80	TOTALS			$ 28,250	$ 2,897	$ 2,897	$		$ 12,247	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)	$	2,502,645	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	88,361	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	88,361	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)	$	2,016,595	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNTY # 0005785 Report Period Beginning: 09/01/09 Ending: 08/31/10

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: *

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.	/2011	$
13.	/2012	$
14.	/2013	$

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

* 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNTY # 0005785 Report Period Beginning: 09/01/09 Ending: 08/31/10

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNTY # 0005785 Report Period Beginning: 09/01/09 Ending: 08/31/10

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

	1	2	3	4	5	6	7	8	
	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 prescrpts							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.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNTY # 0005785 Report Period Beginning: 09/01/09 Ending: 08/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 08/31/10 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 797,862	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	109,141		3
4	Supply Inventory (priced at lower cost/mark)	11,351		4
5	Short-Term Investments			5
6	Prepaid Insurance	15,096		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Interest Receivable	605		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 934,055	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,862,139		12
13	Land	11,477		13
14	Buildings, at Historical Cost	1,042,497		14
15	Leasehold Improvements, at Historical Cost	213,766		15
16	Equipment, at Historical Cost	1,237,170		16
17	Accumulated Depreciation (book methods)	(2,016,595)		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)**	$ 2,350,454	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,284,509	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 34,389	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	47,721		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	Accrued Vacation	59,031		36
37	Payroll Taxes Withheld	1,606		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 142,747	$	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)**	$ 142,747	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,141,762	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,284,509	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNTY # 0005785 Report Period Beginning: 09/01/09 Ending: 08/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,935,248	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,935,248	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	206,514	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)**	$ 206,514	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)**	$ 3,141,762	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNTY # 0005785 Report Period Beginning: 09/01/09 Ending: 08/31/10

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,943,590	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,943,590	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	19,064	13
14	Non-Patient Meals	5,417	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)**	$ 24,481	23
	D. Non-Operating Revenue		
24	Contributions	14,685	24
25	Interest and Other Investment Income***	134,178	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 148,863	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)**	$ 3,116,934	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	828,610	31
32	Health Care	1,304,475	32
33	General Administration	631,640	33
	B. Capital Expense		
34	Ownership	100,825	34
	C. Ancillary Expense		
35	Special Cost Centers	18,042	35
36	Provider Participation Fee	26,828	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,910,420	40
41	**Income before Income Taxes (line 30 minus line 40)****	206,514	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 206,514	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.** **SEE ACCOUNTANTS' COMPILATION REPORT**

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

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNTY # 0005785 Report Period Beginning: 09/01/09 Ending: 08/31/10

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,820	2,056	$ 63,507	$ 30.89	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,423	9,579	207,640	21.68	3
4	Licensed Practical Nurses	10,344	11,951	229,850	19.23	4
5	CNAs & Orderlies	37,437	44,778	489,571	10.93	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,542	1,542	21,164	13.73	8
9	Activity Director	1,888	2,192	32,497	14.83	9
10	Activity Assistants	7,141	8,332	84,122	10.10	10
11	Social Service Workers	1,151	3,218	44,717	13.90	11
12	Dietician					12
13	Food Service Supervisor	1,780	2,128	37,113	17.44	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,998	20,074	197,837	9.86	15
16	Dishwashers					16
17	Maintenance Workers	4,053	4,647	51,730	11.13	17
18	Housekeepers	9,413	11,362	114,843	10.11	18
19	Laundry	3,814	4,367	44,630	10.22	19
20	Administrator	1,918	2,216	92,067	41.55	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,782	4,250	48,583	11.43	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) LNA	2,489	3,122	27,376	8.77	33
34	TOTAL (lines 1 - 33)	113,993	135,814	$ 1,787,247 *	$ 13.16	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	66	$ 8,342	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	40	874	10-3	39
40	Physical Therapy Consultant	65	2,194	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	4	888	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	175	$ 12,298		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	44	247	10-3	52
53	TOTAL (lines 50 - 52)	44	$ 247		53

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNTY # 0005785 Report Period Beginning: 09/01/09 Ending: 08/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JAMES HUBER	ADMINISTRATOR	0	$ 92,067
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 92,067

B. Administrative - Other

Description	Amount
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
CLIFTON GUNDERDERSON LLP	ACCOUNTING	$ 13,800
DUANE MORRIS LLP	LEGAL	70,934
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 84,734

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 39,693
Unemployment Compensation Insurance	
FICA Taxes	138,255
Employee Health Insurance	115,025
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE PHYSICALS	1,302
401 (K)	9,261
TOTAL (agree to Schedule V, line 22, col.8)	$ 303,536

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed ____)	
AANAC	110
IHCA DUES	4,085
HPSI DUES	24
IHCA DUES SPENT ON LOBBYING	(1,276)
HFPA INTERNATIONAL	150
OTHER SUBSCRIPTIONS AND FEES	1,471
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,564

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
MILEAGE REIMBURSEMENT - ERRANDS	306
NURSING/PATIENTS	266
Seminar Expense	
TRAVEL/MEETING/CONFERENCES	3,560
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,132

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNTY # 0005785 Report Period Beginning: 09/01/09 Ending: 08/31/10

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNTY # 0005785 Report Period Beginning: 09/01/09 Ending: 08/31/10

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 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. $ **17,706** 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.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **5,417**

(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? **6%**
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**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

RESTHAVE HOME OF WHITESIDE COUNTY, ILLINOIS
EXPENSES RELATING TO WASTE REMOVAL
SCHEDULE V, LINE 7, COLUMN 3
09/01/09 - 08/31/10

SCHEDULE V, LINE 7, COLUMN 3 INCLUDES WASTE REMOVAL COSTS OF $2,575.41, WHICH IS BROKEN DOWN AS FOLLOWS:

DATE	AMOUNT	PAYEE
9/29/2009	157.30	MORNING DISPOSAL, INC
10/27/2009	157.30	MORNING DISPOSAL, INC
12/2/2009	157.30	MORNING DISPOSAL, INC
1/13/2010	215.51	MORNING DISPOSAL, INC
1/27/2010	236.00	MORNING DISPOSAL, INC
2/26/2010	236.00	MORNING DISPOSAL, INC
3/26/2010	236.00	MORNING DISPOSAL, INC
4/27/2010	236.00	MORNING DISPOSAL, INC
6/2/2010	236.00	MORNING DISPOSAL, INC
6/30/2010	236.00	MORNING DISPOSAL, INC
7/28/2010	236.00	MORNING DISPOSAL, INC
8/25/2010	236.00	MORNING DISPOSAL, INC
	$ 2,575.41	

RESTHAVE HOME OF WHITESIDE COUNTY, ILLINOIS
OTHER EXPENSES
SCHEDULE V - COST CENTER EXP - LINE 36
09/01/09 - 08/31/10

INVESTMENT EXPENSE	12,464
	$ 12,464

LINE 36, SCHEDULE V OF THE COST REPORT INITIALLY REPORTS CAPITAL EXPENSE OF $12,464
THIS AMOUNT REPRESENTS INVESTMENT EXPENSES AND GAIN/LOSSES FOR THE CURRENT FISCAL YEAR AND IS COMPLETELY ADJUSTED OUT ON LINE 29 OF SCHEDULE VI - ADJUSTMENT DETAIL
THEREFORE, ALL INTEREST INCOME OF $134,178 IS INCLUDED ON SCHEDULE XVII - INCOME STATEMENT

RESTHAVE HOME OF WHITESIDE COUNTY, ILLINOIS
TRAVEL AND SEMINAR DETAIL - SCHEDULE V, LINE 24
09/01/09 - 08/31/10

DATE	AMOUNT	PAYEE
12/30/2009	22.00	KARLA BURN
4/13/2010	15.00	JAMIE TROUTMAN
5/21/2010	12.00	JAMIE TROUTMAN
7/6/2010	84.00	KARLA BURN
7/14/2010	20.00	JAMIE TROUTMAN
8/11/2010	113.00	KARLA BURN
	266.00	NURSING/PATIENTS

DATE	AMOUNT	PAYEE
9/3/2009	16.00	MARCIA BLEAN
11/27/2009	15.00	WENDELL STROWD
12/22/2009	15.00	JAMES HUBER
1/19/2010	40.00	JAMES HUBER
2/2/2010	20.00	JAMES HUBER
3/4/2010	40.00	JAMES HUBER
5/13/2010	20.00	JAMES HUBER
6/16/2010	20.00	JAMES HUBER
6/30/2010	20.00	JAMES HUBER
7/6/2010	20.00	JAMES HUBER
8/17/2010	20.00	JAMES HUBER
8/31/2010	60.00	AJE
	306.00	ERRANDS

DATE	AMOUNT	PAYEE
9/23/2009	14.72	NANCY VANZUIDEN
7/20/2010	35.00	NANCY VANZUIDEN
9/23/2009	127.00	DEBBIE LETCHER
9/23/2009	1,626.81	ANN REED
11/11/2009	117.37	JAMES HUBER
6/2/2010	95.70	JAMES HUBER
7/28/2010	120.00	JAMES HUBER
8/17/2010	12.95	JAMES HUBER
9/23/2009	355.95	BONNIE BAUSCHER
9/23/2009	95.50	BONNIE BAUSCHER
9/23/2009	102.50	MARCIA BLEAN
10/13/2009	16.00	MARCIA BLEAN
9/23/2009	126.00	KIMBERLY STRAIGHT
9/23/2009	120.00	SUE VILMONT
11/11/2009	50.00	KIMBERLY STRAIGHT
5/11/2010	83.50	AMY BROWN
6/16/2010	110.00	JANICE STUART
6/22/2010	7.44	JEANNE STROBBE
6/22/2010	56.40	LISA DALTON
6/30/2010	183.50	KIMBERLY STRAIGHT
6/16/2010	104.00	KARLA BURN
	3,560.34	MEETINGS/CONFERENCES

TOTAL 4,132.34

RESTHAVE HOME OF WHITESIDE COUNTY, ILLINOIS
EXPENSES RELATING TO NURSE AID TRAINING PROGRAMS
SCHEDULE XIII
09/01/09 - 08/31/10

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

RESTHAVE HOME OF WHITESIDE COUNTY, ILLINOIS
LEGAL EXPENSES
SCHEDULE XIX, SCHEDULE XX (19)
09/01/09 - 08/31/10

DATE	AMOUNT	PAYEE	DESCRIPTION
10/23/2009	82.00	DUANE MORRIS	GENERAL SERVICES
2/10/2010	205.00	DUANE MORRIS	PHONE CONFERENCE CONCERNING EMPLOYMENT MATTER
3/4/2010	3,647.50	DUANE MORRIS	LABOR - EMPLOYMENT MATTERS
3/18/2010	6,053.00	DUANE MORRIS	HANDBOOK MEETING
4/27/2010	9,272.50	DUANE MORRIS	HANDBOOK MEETING
6/2/2010	18,797.50	DUANE MORRIS	LABOR EMPLOYMENT MATTERS
6/22/2010	5,316.47	DUANE MORRIS	EMPLOYMENT MATTERS
7/15/2010	12,687.00	DUANE MORRIS	EMPLOYMENT MATTERS AND HANDBOOK
8/25/2010	8,066.50	DUANE MORRIS	GENERAL HANDBOOK
AJE	6,555.50	DUANE MORRIS	EMPLOYMENT MATTERS, HANDBOOK
AJE	251.00	DUANE MORRIS	EMPLOYMENT MATTERS, HANDBOOK
	70,933.97	TOTAL LEGAL FEES	