

Facility Name & ID Number BELHAVEN NURSING & REHABILITATION CENTER

0048215 Report Period Beginning: 7/11/06 Ending: 1/31/07

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	221	Skilled (SNF)	221	45,305	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	221	TOTALS	221	45,305	7

B. Census-For the entire report period.

	1 Level of Care	3 Patient Days by Level of Care and Primary Source of Payment				5
		2 Medicaid Recipient		4 Other	Total	
		Private Pay				
8	SNF	21,184	2,746	5,810	29,740	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,184	2,746	5,810	29,740	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.64%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

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 7/11/06

J. Was the facility purchased or leased after January 1, 1978?
YES Date 7/11/06 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 221 and days of care provided 4,403

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

STATE OF ILLINOIS

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Facility Name & ID Number **BELHAVEN NURSING & REHABILITATI** # **0048215** Report Period Beginning: **7/11/06** Ending: **1/31/07****V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	174,816	17,641	15,313	207,770		207,770	(95)	207,675		1
2	Food Purchase		137,549		137,549		137,549		137,549		2
3	Housekeeping	177,007	21,381		198,388		198,388		198,388		3
4	Laundry	93,709	9,687		103,396		103,396		103,396		4
5	Heat and Other Utilities			168,920	168,920		168,920		168,920		5
6	Maintenance	53,067	16,788	21,113	90,968		90,968	(394)	90,574		6
7	Other (specify):*										7
8	TOTAL General Services	498,599	203,046	205,346	906,991		906,991	(489)	906,502		8
	B. Health Care and Programs										
9	Medical Director			16,000	16,000		16,000		16,000		9
10	Nursing and Medical Records	1,509,955	86,188	72,311	1,668,454		1,668,454		1,668,454		10
10a	Therapy			363,951	363,951		363,951		363,951		10a
11	Activities	83,091	3,505		86,596		86,596		86,596		11
12	Social Services	33,157		1,840	34,997		34,997		34,997		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,626,203	89,693	454,102	2,169,998		2,169,998		2,169,998		16
	C. General Administration										
17	Administrative	56,053			56,053		56,053		56,053		17
18	Directors Fees										18
19	Professional Services			166,869	166,869		166,869	(145,480)	21,389		19
20	Dues, Fees, Subscriptions & Promotions			3,801	3,801		3,801		3,801		20
21	Clerical & General Office Expenses	126,842	59,001	6,185	192,028		192,028	(10,905)	181,123		21
22	Employee Benefits & Payroll Taxes			304,974	304,974		304,974	43,824	348,798		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,581	5,581		5,581	51	5,632		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			157,756	157,756		157,756	17,767	175,523		26
27	Other (specify):*										27
28	TOTAL General Administration	182,895	59,001	645,166	887,062		887,062	(94,743)	792,319		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,307,697	351,740	1,304,614	3,964,051		3,964,051	(95,232)	3,868,819		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 OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			18,464	18,464		18,464	81,227	99,691			30
31	Amortization of Pre-Op. & Org.							153,510	153,510			31
32	Interest			26,950	26,950		26,950	416,050	443,000			32
33	Real Estate Taxes							159,423	159,423			33
34	Rent-Facility & Grounds			980,000	980,000		980,000	(980,000)				34
35	Rent-Equipment & Vehicles			404	404		404		404			35
36	Other (specify):*											36
37	TOTAL Ownership			1,025,818	1,025,818		1,025,818	(169,790)	856,028			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		233,992		233,992		233,992		233,992			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			69,466	69,466		69,466		69,466			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		233,992	69,466	303,458		303,458		303,458			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,307,697	585,732	2,399,898	5,293,327		5,293,327	(265,022)	5,028,305			45

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

Facility Name & ID Number **BELHAVEN NURSING & REHABILITATION CENTER # 0048215**

Report Period Beginning: **7/11/06**

Ending: **1/31/07**

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	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				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	(92)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(95)	1		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	(4,875)	21		18
19	Entertainment				19
20	Contributions	(500)	21		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	(6,154)	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	(394)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (12,110)		\$	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)	(252,912)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (252,912)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (265,022)		37

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

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

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

STATE OF ILLINOIS
BELHAVEN NURSING & REHABILITATION CENTER

ID# 0048215
 Report Period Beginning: 7/11/06
 Ending: 1/31/07

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	VENDING INCOME	\$ (394)	6	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				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	Total	(394)		48
49				49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BELHAVEN NURSING & REHABILITATION CENTER

0048215

Report Period Beginning:

7/11/06

Ending:

1/31/07

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(95)	0	0	0	0	0	0	0	0	0	0	(95)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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	(394)	0	0	0	0	0	0	0	0	0	0	(394)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(489)	0	0	0	0	0	0	0	0	0	0	(489)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	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	(145,480)	0	0	0	0	0	0	0	0	0	(145,480)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(11,529)	624	0	0	0	0	0	0	0	0	0	(10,905)	21
22	Employee Benefits & Payroll Taxes	0	43,824	0	0	0	0	0	0	0	0	0	43,824	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	51	0	0	0	0	0	0	0	0	0	51	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	17,767	0	0	0	0	0	0	0	0	0	17,767	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(11,529)	(83,214)	0	(94,743)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(12,018)	(83,214)	0	(95,232)	29								

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
SEE ATTACHMENT #1						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	19 PROFESSIONAL FEES	\$ 148,000	NEW YORK BOYS MANAGEMENT	46.25%	\$	\$(148,000)
2	V	19 ACCOUNTING & PROF. FEES				2,520	2,520
3	V	21 BANK SERVICE CHG, MISC				507	507
4	V	22 LIFE INSURANCE & PENSION				43,824	43,824
5	V	24 TRAVEL & ENTERTAINMENT				51	51
6	V	34 RENT	980,000	MIDWAY NEUROLOGICAL AND REHABILITATION REALTY, LLC			(980,000)
7	V	31 AMORTIZATION				153,510	153,510
8	V	33 PROPERTY TAXES				159,423	159,423
9	V	21 BANK SERVICE CHG				117	117
10	V	26 INSURANCE				17,767	17,767
11	V	32 INTEREST				416,142	416,142
12	V	30 DEPRECIATION				81,227	81,227
13	V						
14	Total		\$ 1,128,000			\$ 875,088	\$ * (252,912)

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

ATTACHMENT #1

OWNERS

NAME	OWNERSHIP %
MOISHE GUBIN	35.000%
MICHAEL BLISKO	35.000%
A&F GENERAL PARTNERSHIP	<u>30.000%</u>
	<u>100.000%</u>

OTHER RELATED BUSINESS ENTITIES

NAME	CITY	TYPE OF BUSINESS
NEW YORK BOYS MANAGEMENT	CROWN POINT, IN	MANAGEMENT CO.

NOTE: NEW YORK BOYS MANAGEMENT IS OWNED BY MOISHE GUBIN AND MICHAEL BLISKO.

Facility Name & ID Number BELHAVEN NURSING & REHABILITAT # 0048215 Report Period Beginning: 7/11/06 Ending: 1/31/07

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	BEN FRIEDMAN	ADMINISTRATOR	ADMIN	0.00		40	100.00	SALARY	\$ 56,053	17-1	1
2	MICHAEL BLISKO			35.00							2
3	MOISHE GUBIN			35.00							3
4	A&F GENERAL PARTNERSHIP			30.00							4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 56,053		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 BELHAVEN NURSING & REHABILITATION CENTER # 0048215 Report Period Beginning: 7/11/06 Ending: 1/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$			1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number **BELHAVEN NURSING & REHABILITATION** # **0048215** Report Period Beginning: **7/11/06** Ending: **1/31/07**

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2	3	4	5	6		7	8	9	10	
						Original	Balance					
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO									
	A. Directly Facility Related											
	Long-Term											
1	MIDWEST BANK & TRUST CO.	X		MORTGAGE	\$69,000.00	7/1/06	\$ 8,179,000	\$ 8,134,364	7/1/36	7.7500	\$ 288,017	1
2	A&F GENERAL PARTNERSHIP	X		MORTGAGE		7/1/06	2,250,000	2,137,500	7/1/16	10.0000	128,125	2
3												3
4												4
5												5
	Working Capital											
6	MIDWEST BANK & TRUST CO.	X		WORKING CAPITAL	NONE	7/11/06	2,800,000			8.2500	26,950	6
7												7
8												8
9	TOTAL Facility Related				\$69,000.00		\$ 13,229,000	\$ 10,271,864			\$ 443,092	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 13,229,000	\$ 10,271,864			\$ 443,092	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A 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

<div style="border: 1px solid black; padding: 2px; display: inline-block;"> Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report. </div>																							
1. Real Estate Tax accrual used on 2005 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 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	159,423 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.		\$	159,423 7																				
Real Estate Tax History:																							
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2001</td><td>8</td></tr> <tr><td>2002</td><td>9</td></tr> <tr><td>2003</td><td>10</td></tr> <tr><td>2004</td><td>11</td></tr> <tr><td>2005</td><td>417,369 12</td></tr> </table>	2001	8	2002	9	2003	10	2004	11	2005	417,369 12	<table border="1"> <tr><td colspan="2">FOR BHF USE ONLY</td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2005 \$</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 2005 \$	14	PLUS APPEAL COST FROM LINE 5 \$	15	LESS REFUND FROM LINE 6 \$	16	AMOUNT TO USE FOR RATE CALCULATION \$	
2001	8																						
2002	9																						
2003	10																						
2004	11																						
2005	417,369 12																						
FOR BHF USE ONLY																							
13	FROM R. E. TAX STATEMENT FOR 2005 \$																						
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: 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 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 2006 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,

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BELHAVEN NURSING & REHABILITATION CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0048215

CONTACT PERSON REGARDING THIS REPORT DANIEL S. GAAFAR

TELEPHONE (317) 237-5500 FAX #: (317) 237-5503

A. Summary of Real Estate Tax Costs

Enter the tax index number and real estate tax assessed for 2005 on the lines provided below. Enter only the portion of total 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. 25-19-110-040-0000	NURSING HOME	\$ 208,684.00	\$ 208,684.00
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>208,684.00</u>	\$ <u>208,684.00</u>

B. Real Estate Tax Cost Allocation:

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 X 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006

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.

A. Square Feet: 78,370 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 3

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 ground (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)

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: 4,500,000 2. Number of Years Over Which it is Being Amortized: 15
 3. Current Period Amortization: 153,510 4. Dates Incurred: Prior to 7/11/06

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Nursing Home		7/11/2006	\$ 100,000	1
2					2
3	TOTALS			\$ 100,000	3

STATE OF ILLINOIS

Facility Name & ID Number **BELHAVEN NURSING & REHABILITATION CENTER**

0048215

Report Period Beginning:

7/11/06

Ending:

1/31/07

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	221	2006		\$ 5,500,000	\$ 70,513	39	\$ 70,513	\$	\$ 70,513
5									
6									
7									
8									
Improvement Type**									
9	Dish Machinge		12/8/2006	1,875	48	39	48		48
10	Wanderguard Security Camera		7/25/2006	37,000	949	39	949		949
11	2nd Floor Remodeling		11/1/2006	26,392	677	39	677		677
12	Elevator items		3/2/2005	3,495	90	39	90		90
13	Lights		3/10/2005	10,561	271	39	271		271
14	Dish Machinge		6/5/2005	1,100	28	39	28		28
15	Improvements		10/1/2006	600	15	39	15		15
16	Fast Signs		1/9/2007	3,352		39			
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

STATE OF ILLINOIS

Facility Name & ID Number **BELHAVEN NURSING & REHABILITATION CENTER**

0048215

Report Period Beginning:

7/11/06

Ending:

1/31/07

XI. OWNERSHIP COSTS (continued)

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

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,584,375	\$ 72,591		\$ 72,591	\$	\$ 72,591	70

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

Facility Name & ID Number **BELHAVEN NURSING & REHABILITATION CEN# 0048215** Report Period Beginning: **7/11/06** Ending: **1/31/07**

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	\$						71
72	Current Year Purchases	264,859	16,386	16,386		5	16,386	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 264,859	\$ 16,386	\$ 16,386	\$		\$ 16,386	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	N/A			\$	\$	\$			\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 5,949,234	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 88,977	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 88,977	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)	\$ 88,977	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	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: NOT APPLICABLE

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

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.	_____	\$ _____
13.	_____	\$ _____
14.	_____	\$ _____

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	<u>N/A</u>		\$	\$	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.

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			Total
		1 Drop-outs	2 Completed	3 Contract	
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)	\$			

- (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.

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	

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5	6	7	8		
			Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)						Total Cost (Col. 3 + 5 + 6)
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	10a-3	hrs	\$		\$	185,486	\$			\$	185,486	1	
2	Licensed Speech and Language Development Therapist	10a-3	hrs				5,249					5,249	2	
3	Licensed Recreational Therapist		hrs										3	
4	Licensed Physical Therapist	10a-3	hrs				173,216					173,216	4	
5	Physician Care		visits										5	
6	Dental Care		visits										6	
7	Work Related Program		hrs										7	
8	Habilitation		hrs										8	
9	Pharmacy	39-2	# of prescripts						224,238			224,238	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10	
11	Academic Education		hrs										11	
12	Exceptional Care Program												12	
13	Other (specify): Radiology & Lab	39-2							9,754			9,754	13	
14	TOTAL			\$		\$	363,951	\$	233,992	\$		597,943	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.

STATE OF ILLINOIS

Facility Name & ID Number **BELHAVEN NURSING & REHABILITATION CENTER # 0048215** Report Period Beginning: **7/11/06** Ending: **1/31/07**
 XV. BALANCE SHEET - Unrestricted Operating Fund. As of **1/31/07** (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 275,773	\$ 498,996	1
2	Cash-Patient Deposits	(2,512)	(2,512)	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,231,133	2,731,133	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	153,302	153,302	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,657,696	\$ 3,380,919	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		100,000	13
14	Buildings, at Historical Cost		5,500,000	14
15	Leasehold Improvements, at Historical Cost	114,258	114,258	15
16	Equipment, at Historical Cost	114,859	264,859	16
17	Accumulated Depreciation (book methods)	(18,464)	(99,691)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		105,292	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(3,510)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Goodwill & deposits		4,350,000	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 210,653	\$ 10,331,208	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,868,349	\$ 13,712,127	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 442,867	\$ 442,867	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	365,226	365,226	30
31	Accrued Taxes Payable (excluding real estate taxes)	605	420,605	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	Settlement Reserve	1,250,000	1,250,000	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,058,698	\$ 2,478,698	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	800,000	2,937,500	39
40	Mortgage Payable		8,134,364	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	Retained Earnings	(77,812)	(77,712)	43
44	Net Income	(182,187)		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 540,001	\$ 10,994,152	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,598,699	\$ 13,472,850	46
47	TOTAL EQUITY(page 18, line 24)	\$ 269,650	\$ 239,277	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,868,349	\$ 13,712,127	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	269,650	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)	\$ 269,650	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)	\$ 269,650	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Facility Name & ID Number BELHAVEN NURSING & REHABILITATION C I # 0048215 Report Period Beginning: 7/11/06

Page 19
Ending: 1/31/07**VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.****Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,025,632	1
2	Discounts and Allowances for all Levels	(506,142)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,519,490	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	735,739	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 735,739	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		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	165,330	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	13,994	19
20	Radiology and X-Ray	1,720	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 181,044	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	92	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 92	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	126,217	28
28a	Vending Income	394	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 126,611	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,562,976	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	906,991	31
32	Health Care	2,169,998	32
33	General Administration	887,061	33
B. Capital Expense			
34	Ownership	1,025,818	34
C. Ancillary Expense			
35	Special Cost Centers	233,992	35
36	Provider Participation Fee	69,466	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,293,326	40
41	Income before Income Taxes (line 30 minus line 40)**	269,650	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 269,650	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

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

Facility Name & ID Number BELHAVEN NURSING & REHABILITATION CENTER

0048215

Report Period Beginning: 7/11/06

Ending: 1/31/07

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,208	1,247	\$ 47,944	\$ 38.45	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,429	5,614	133,993	23.87	3
4	Licensed Practical Nurses	28,184	28,035	692,204	24.69	4
5	CNAs & Orderlies	57,838	62,549	607,085	9.71	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,130	1,286	12,454	9.68	8
9	Activity Director	8,319	8,546	83,091	9.72	9
10	Activity Assistants					10
11	Social Service Workers	2,400	2,502	33,157	13.25	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,826	15,753	174,816	11.10	15
16	Dishwashers					16
17	Maintenance Workers	1,920	2,421	53,067	21.92	17
18	Housekeepers	14,051	16,103	177,007	10.99	18
19	Laundry	7,613	8,748	93,709	10.71	19
20	Administrator	936	1,487	56,053	37.70	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,062	6,667	126,842	19.03	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	941	1,112	16,275	14.64	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	150,857	162,070	\$ 2,307,697 *	\$ 14.24	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	390	\$ 13,663	10-3	35
36	Medical Director				36
37	Medical Records Consultant	36	1,274	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	33	1,650	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	53	1,840	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	512	\$ 18,427		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	120	\$ 6,000	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	120	\$ 6,000		53

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 5 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 15,263 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 69,466
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? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0%
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? N/A
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? NO
Attach invoices and a summary of services for all architect and appraisal fees.