

Facility Name & ID Number BELHAVEN NURSING & REHABILITATION CENTER

0048215 Report Period Beginning: 1/1/08 Ending: 12/31/08

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	221	Skilled (SNF)	221	80,886	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	80,886	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	56,509	2,954	13,573	73,036	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	56,509	2,954	13,573	73,036	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.29%

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 7,284

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: 12/31/08 Fiscal Year: 12/31/08

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

Facility Name & ID Number BELHAVEN NURSING & REHABILITATION # 0048215 Report Period Beginning: 1/1/08 Ending: 12/31/08

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	382,209	428,737	8,981	819,927		819,927	(1,760)	818,167		1
2	Food Purchase										2
3	Housekeeping	279,199	36,000		315,199		315,199		315,199		3
4	Laundry	152,762	36,193		188,955		188,955		188,955		4
5	Heat and Other Utilities			438,223	438,223		438,223	(4,989)	433,234		5
6	Maintenance	64,485	14,794	74,348	153,627		153,627	(2,845)	150,782		6
7	Other (specify):*										7
8	TOTAL General Services	878,655	515,724	521,552	1,915,931		1,915,931	(9,594)	1,906,337		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	3,619,935	612,923	19,149	4,252,007		4,252,007	12,600	4,264,607		10
10a	Therapy			746,977	746,977		746,977		746,977		10a
11	Activities	130,467	13,943		144,410		144,410		144,410		11
12	Social Services	60,720		5,569	66,289		66,289	(207)	66,082		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,811,122	626,866	783,695	5,221,683		5,221,683	12,393	5,234,076		16
	C. General Administration										
17	Administrative	89,378			89,378		89,378	62,866	152,244		17
18	Directors Fees										18
19	Professional Services			284,502	284,502		284,502	(194,530)	89,972		19
20	Dues, Fees, Subscriptions & Promotions			2,447	2,447		2,447		2,447		20
21	Clerical & General Office Expenses	243,013	106,104	1,565	350,682		350,682	(25,610)	325,072		21
22	Employee Benefits & Payroll Taxes			770,921	770,921		770,921	33,835	804,756		22
23	Inservice Training & Education										23
24	Travel and Seminar			21,994	21,994		21,994	9,420	31,414		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			256,221	256,221		256,221	12,042	268,263		26
27	Other (specify):*										27
28	TOTAL General Administration	332,391	106,104	1,337,650	1,776,145		1,776,145	(101,977)	1,674,168		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,022,168	1,248,694	2,642,897	8,913,759		8,913,759	(99,178)	8,814,581		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 BELHAVEN NURSING & REHABILITATION CENTER #0048215 Report Period Beginning: 1/1/08 Ending: 12/31/08

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			97,638	97,638	97,638	141,448	239,086				30
31	Amortization of Pre-Op. & Org.						307,019	307,019				31
32	Interest			83,872	83,872	83,872	981,444	1,065,316				32
33	Real Estate Taxes						364,217	364,217				33
34	Rent-Facility & Grounds			1,680,000	1,680,000	1,680,000	(1,680,000)					34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			1,861,510	1,861,510	1,861,510	114,128	1,975,638				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		230,610		230,610	230,610		230,610				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			121,330	121,330	121,330		121,330				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		230,610	121,330	351,940	351,940		351,940				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,022,168	1,479,304	4,625,737	11,127,209	11,127,209	14,950	11,142,159				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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				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	(21,007)	30		9
10	Interest and Other Investment Income	(2,175)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(241)	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				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	(21,666)	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	(2,845)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (47,934)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	62,884	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 62,884		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 14,950		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					44
45	Other-Attach Schedule		X		45
46	Other-Attach Schedule		X		46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS
 BELHAVEN NURSING & REHABILITATION CENTER

ID# 0048215

Report Period Beginning: 1/1/08

Ending: 12/31/08

Sch. V Line Reference

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Vending Income	\$ (2,845)	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				48
49	Total	(2,845)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BELHAVEN NURSING & REHABILITATION CENTER

0048215

Report Period Beginning:

1/1/08

Ending:

12/31/08

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(241)	(1,519)	0	0	0	0	0	0	0	0	0	(1,760)	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	(4,989)	0	0	0	0	0	0	0	0	0	(4,989)	5
6	Maintenance	(2,845)	0	0	0	0	0	0	0	0	0	0	(2,845)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(3,086)	(6,508)	0	0	0	0	0	0	0	0	0	(9,594)	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	12,600	0	0	0	0	0	0	0	0	0	12,600	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	(207)	0	0	0	0	0	0	0	0	0	(207)	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	12,393	0	0	0	0	0	0	0	0	0	12,393	16
	C. General Administration													
17	Administrative	0	62,866	0	0	0	0	0	0	0	0	0	62,866	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(211,730)	17,200	0	0	0	0	0	0	0	0	(194,530)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(21,666)	(3,944)	0	0	0	0	0	0	0	0	0	(25,610)	21
22	Employee Benefits & Payroll Taxes	0	33,835	0	0	0	0	0	0	0	0	0	33,835	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	9,420	0	0	0	0	0	0	0	0	0	9,420	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	12,042	0	0	0	0	0	0	0	0	0	12,042	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(21,666)	(97,511)	17,200	0	(101,977)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(24,752)	(91,626)	17,200	0	(99,178)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BELHAVEN NURSING & REHABILITATION CENTER # 0048215 Report Period Beginning: 1/1/08 Ending: 12/31/08

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(21,007)	162,455	0	0	0	0	0	0	0	0	0	141,448	30
31	Amortization of Pre-Op. & Org.	0	0	307,019	0	0	0	0	0	0	0	0	307,019	31
32	Interest	(2,175)	0	983,619	0	0	0	0	0	0	0	0	981,444	32
33	Real Estate Taxes	0	0	364,217	0	0	0	0	0	0	0	0	364,217	33
34	Rent-Facility & Grounds	0	(1,680,000)	0	0	0	0	0	0	0	0	0	(1,680,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(23,182)	(1,517,545)	1,654,855	0	114,128	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)	(47,934)	(1,609,171)	1,672,055	0	14,950	45							

Facility Name & ID Number BELHAVEN NURSING & REHABILITATION CENTER

0048215

Report Period Beginning:

1/1/08

Ending:

12/31/08

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	\$ 245,202	NEW YORK BOYS		\$ 33,472	\$ (211,730)
2	V	10 NURSING & MED REC	22,000	NEW YORK BOYS		34,600	12,600
3	V	17 ADMIN WAGES		NEW YORK BOYS		62,866	62,866
4	V	5 TELEPHONE	5,617	NEW YORK BOYS		628	(4,989)
5	V	21 OTHER ADMIN EXP	8,652	NEW YORK BOYS		4,391	(4,261)
6	V	22 FRINGE BENEFITS	625	NEW YORK BOYS		34,460	33,835
7	V	24 TRAVEL	267	NEW YORK BOYS		9,687	9,420
8	V	1 DIETARY	11,400	NEW YORK BOYS		9,881	(1,519)
9	V	12 SOCIAL SERVICES	207	NEW YORK BOYS			(207)
10	V	34 RENT	1,680,000	BELHAVEN REALTY, LLC			(1,680,000)
11	V	21 OTHER ADMIN EXP				317	317
12	V	30 DEPRECIATION				162,455	162,455
13	V	26 LIABILITY INSURANCE				12,042	12,042
14	Total		\$ 1,973,970			\$ 364,799	\$ * (1,609,171)

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BELHAVEN NURSING & REHABILITATION CENTER # 0048215 Report Period Beginning: 1/1/08 Ending: 12/31/08

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	32	INTEREST	\$			\$ 983,619	\$ 983,619	15
16	V	19	PROFESSIONAL FEES				17,200	17,200	16
17	V	33	REALESTATE TAXES				364,217	364,217	17
18	V	31	AMMORTIZATION				307,019	307,019	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 1,672,055	\$ * 1,672,055	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

ATTACHMENT #1

OWNERS

NAME	OWNERSHIP %
MICHAEL BLISKO	30.000%
MOISHE GUBIN	32.000%
STEVEN BLISKO	5.000%
BERNARD STEINBURG	3.000%
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: 1/1/08 Ending: 12/31/08

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	\$ 65,201	17-1	1
2	Michael Perl	Administrator	Admin	0.00		40	100.00	Salary	24,177	17-1	2
3	Michael Blisko			35.00							3
4	Moishe Gubin			35.00							4
5	A&F General Partnership			30.00							5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 89,378		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 BELHAVEN NURSING & REHABILITATION CENTER # 0048215 Report Period Beginning: 1/1/08 Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	HUD		x	MORTGAGE	\$105,131.00	10/24/08	\$ 10,616,000	\$ 10,608,631	10/24/43	5.9900	\$ 216,585	1								
2	MIDWEST BANK & TRUST CO.		X	MORTGAGE	\$69,000.00	7/1/06	8,179,000		7/1/36	7.7500	577,878	2								
3	A&F GENERAL PARTNERSHIP		X	MORTGAGE		7/1/06	2,250,000		7/1/16	10.0000	189,156	3								
4												4								
5												5								
Working Capital																				
6	MIDWEST BANK & TRUST CO.		X	WORKING CAPITAL	NONE	7/11/06	2,800,000	2,600,000		8.2500	83,872	6								
7												7								
8												8								
9	TOTAL Facility Related				\$174,131.00		\$ 23,845,000	\$ 13,208,631			\$ 1,067,491	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 23,845,000	\$ 13,208,631			\$ 1,067,491	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.)

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.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2008 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME 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 Cost

Enter the tax index number and real estate tax assessed for 2007 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>25-19-110-040-0000</u>	<u>Nursing Home</u>	<u>\$ 364,216.00</u>	<u>\$ 364,216.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ 364,216.00	\$ 364,216.00

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

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

Facility Name & ID Number BELHAVEN NURSING & REHABILITATION CENTER

0048215

Report Period Beginning:

1/1/08

Ending:

12/31/08

X. BUILDING AND GENERAL INFORMATION:

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 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).

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: 4,605,292 2. Number of Years Over Which it is Being Amortized: 15
3. Current Period Amortization: 307,019 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	<u>Nursing Home</u>		<u>7/11/2006</u>	<u>\$ 100,000</u>	1
2					2
3	TOTALS			\$ 100,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BELHAVEN NURSING & REHABILITATION CENTER

0048215

Report Period Beginning:

1/1/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9	
	Bed* 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	\$ 141,026	39	\$ 141,026		\$ 352,565	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Dish Machine		12/8/2006	1,875	48	39	48		144	9
10	Wanderguard Security Camera		7/25/2006	37,000	949	39	949		2,847	10
11	Elevator Items		3/2/2005	3,495	90	39	90		270	11
12	Lights		3/10/2005	10,561	271	39	271		813	12
13	Dish Machine		6/5/2005	1,100	28	39	28		84	13
14	Improvements - Paint & Painting Supplies		10/1/2006	600	15	39	15		45	14
15	2nd Floor Remodeling - Cove Base for Rooms		11/1/2006	1,408	36	39	36		108	15
16	2nd Floor Remodeling - Wall Protection & Corner Guards		11/1/2006	2,372	61	39	61		183	16
17	2nd Floor Remodeling - Floor & Tile		11/1/2006	5,418	139	39	139		417	17
18	2nd Floor Remodeling - Paint & Painting Supplies		11/1/2006	14,919	383	39	383		1,149	18
19	2nd Floor Remodeling - Cove Base, Vertical Dividers, Wood Drift		11/1/2006	2,275	58	39	58		174	19
20	Fast Signs		1/9/2007	3,352	86	39	86		171	20
21	Cubicle Curtains		1/9/2007	1,117	29	39	29		57	21
22	Door Kickplates		1/9/2007	576	15	39	15		30	22
23	Draperies, Light Fixtures, Cascades		1/23/2007	28,189	723	39	723		1,446	23
24	Windows		1/23/2007	884	23	39	23		45	24
25	Painting & Supplies		2/1/2007	1,500	38	39	38		74	25
26	Water Pump & Boiler Tank		2/26/2007	8,875	228	39	228		436	26
27	Paint & Supplies		3/1/2007	2,657	68	39	68		125	27
28	Paint & Supplies		4/1/2007	5,520	142	39	142		248	28
29	Thermal Assembly		4/11/2007	2,179	56	39	56		98	29
30	Wall Paper, Wall Protection		5/1/2007	7,306	187	39	187		312	30
31	Paint & Supplies		5/1/2007	4,746	122	39	122		203	31
32	Heating & Cooling Pump		5/7/2007	4,214	108	39	108		180	32
33	Faucet		5/16/2007	1,425	37	39	37		61	33
34	Pump Motor		5/24/2007	910	23	39	23		39	34
35	Paint & Supplies		6/1/2007	8,833	227	39	227		358	35
36	Air Handler		6/4/2007	6,160	158	39	158		250	36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BELHAVEN NURSING & REHABILITATION CENTER

0048215

Report Period Beginning:

1/1/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Wall Protection & Corner Guards	6/27/2007	\$ 7,957	\$ 204	39	\$ 204	\$	\$ 323	37
38	Paint & Supplies	7/1/2007	4,744	122	39	122		182	38
39	Paint & Supplies	8/1/2007	5,247	135	39	135		191	39
40	Electric Work	8/2/2007	5,438	139	39	139		198	40
41	A/C	8/8/2007	2,534	65	39	65		92	41
42	Paint & Supplies	9/1/2007	4,393	113	39	113		150	42
43	Paint & Supplies	10/1/2007	6,499	167	39	167		208	43
44	Lights, Wall Protection, Draperies	10/9/2007	29,587	759	39	759		948	44
45	Shower Valve	11/1/2007	3,650	94	39	94		109	45
46	Paint & Supplies	11/1/2007	3,076	79	39	79		92	46
47	Electric Work	11/9/2007	10,269	263	39	263		307	47
48	Wall Covering	11/28/2007	3,161	81	39	81		95	48
49	Hydraulic Valve	11/28/2007	4,207	108	39	108		126	49
50	Paint & Supplies	12/1/2007	2,065	53	39	53		62	50
51	Kickplates/Wallcoverings	1/11/2008	3,130	80	39	80		80	51
52	Kickplates/Wallcoverings	4/24/2008	4,179	107	39	80	(27)	80	52
53	Wallpaper	1/11/2008	1,537	39	39	39		39	53
54	Sheeting	11/21/2008	1,111	28	39	5	(23)	5	54
55	Plumbing	6/10/2008	2,410	62	39	36	(26)	36	55
56	Water Heater parts replacement	5/13/2008	1,231	32	39	21	(11)	21	56
57	A/C Maintenance	5/15/2005	231	6	39	4	(2)	4	57
58	Valve Replacement	5/13/2008	3,650	94	39	62	(32)	62	58
59	A/C	5/22/2008	2,198	56	39	38	(18)	38	59
60	Air Vent	6/5/2008	813	21	39	12	(9)	12	60
61	Cooling Tower	6/20/2008	4,093	105	39	61	(44)	61	61
62	Freezer parts replacement	9/23/2008	1,208	31	39	10	(21)	10	62
63	Water Heater parts replacement	12/5/2008	1,516	39	39	3	(36)	3	63
64	Water Heater parts replacement	12/24/2008	969	25	39	2	(23)	2	64
65	Electrical	10/22/2008	655	17	39	4	(13)	4	65
66	Dining Room	1/15/2008	3,600	92	39	92		92	66
67	Paint/Remodel	2/5/2008	2,300	59	39	54	(5)	54	67
68	2nd Floor Paint/Remodel	4/4/2008	3,000	77	39	58	(19)	58	68
69	3rd Floor Paint/Remodel	5/16/2008	3,500	90	39	60	(30)	60	69
70	TOTAL (lines 4 thru 69)		\$ 5,803,623	\$ 148,816		\$ 148,477	\$ (339)	\$ 366,736	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number BELHAVEN NURSING & REHABILITATION CENTER

0048215

Report Period Beginning:

1/1/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,803,623	\$ 148,816		\$ 148,477	\$ (339)	\$ 366,736	1
2	Paint/Remodel	5/22/2008	1,500	38	39	26	(12)	26	2
3	Concrete Work	6/6/2008	300	8	39	4	(4)	4	3
4	Remodel - Cabinets/Light Fixtures	9/12/2008	600	15	39	5	(10)	5	4
5	Remodel - Cabinets/Light Fixtures	9/12/2008	1,400	36	39	12	(24)	12	5
6	Remodel Supplies	10/14/2008	600	15	39	4	(11)	4	6
7	Remodel Supplies	1/15/2008	252	6	39	6		6	7
8	Remodel Supplies	2/5/2008	269	7	39	6	(1)	6	8
9	Remodel Supplies	4/14/2008	406	10	39	8	(2)	8	9
10	Remodel Supplies	4/21/2008	663	17	39	13	(4)	13	10
11	Remodel Supplies	4/23/2008	489	13	39	9	(4)	9	11
12	Remodel Supplies	5/16/2008	326	8	39	6	(2)	6	12
13	Remodel Supplies	5/22/2008	465	12	39	8	(4)	8	13
14	Remodel Supplies	9/11/2008	1,106	28	39	9	(19)	9	14
15	Remodel Supplies	9/2/2008	1,470	38	39	13	(25)	13	15
16	Remodel Supplies	9/12/2008	606	16	39	5	(11)	5	16
17	Elevator	4/10/2008	3,006	77	39	58	(19)	58	17
18	Elevator	7/21/2008	5,538	142	39	71	(71)	71	18
19	Elevator	12/26/2008	4,407	113	39	9	(104)	9	19
20	Sprinkler Repairs	7/31/2008	537	14	39	7	(7)	7	20
21	Sprinkler Repairs	8/28/2008	653	17	39	7	(10)	7	21
22	Sprinkler Repairs	8/29/2008	1,510	39	39	16	(23)	16	22
23	Sprinkler Repairs	8/31/2008	1,980	51	39	21	(30)	21	23
24	Sprinkler Repairs	8/31/2008	1,156	30	39	12	(18)	12	24
25	Doors	11/18/2008	350	9	39	1	(8)	1	25
26	Doors	11/20/2008	447	11	39	2	(9)	2	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,833,658	\$ 149,586		\$ 148,815	\$ (771)	\$ 367,074	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number BELHAVEN NURSING & REHABILITATION CEI# 0048215 Report Period Beginning: 1/1/08 Ending: 12/31/08

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	\$ 376,784	\$ 104,506	\$ 84,270	\$ (20,236)	5	\$ 245,869	71
72	Current Year Purchases	38,721	6,005	6,005		5	6,005	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 415,505	\$ 110,511	\$ 90,275	\$ (20,236)		\$ 251,874	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				\$	\$	\$	\$		\$	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)	\$ 6,349,163	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 260,097	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 239,090	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (21,007)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 618,948	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BELHAVEN NURSING & REHABILITATION CENTER # 0048215 Report Period Beginning: 1/1/08 Ending: 12/31/08

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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* 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.

Facility Name & ID Number BELHAVEN NURSING & REHABILITATION CENTER # 0048215 Report Period Beginning: 1/1/08 Ending: 12/31/08

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-3	hrs	\$		\$ 383,121	\$		\$ 383,121	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs			103,203			103,203	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs			260,653			260,653	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				216,103		216,103	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Radiology & Lab	39-2					14,507		14,507	13
14	TOTAL			\$		\$ 746,977	\$ 230,610		\$ 977,587	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BELHAVEN NURSING & REHABILITATION CENTER # 0048215 Report Period Beginning: 1/1/08 Ending: 12/31/08

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/08 (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	\$ 86,840	\$ 846,859	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	4,767,739	4,383,139	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	188,130	188,130	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)	\$ 5,042,709	\$ 5,418,128	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	333,656	333,656	15
16	Equipment, at Historical Cost	265,506	415,506	16
17	Accumulated Depreciation (book methods)	(136,184)	(639,958)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		276,422	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <u>Goodwill</u>)		3,750,000	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 462,978	\$ 9,735,626	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,505,687	\$ 15,153,754	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 622,528	\$ 622,528	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	491,531	491,531	30
31	Accrued Taxes Payable (excluding real estate taxes)		420,000	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Settlement Reserve</u>	375,000	375,000	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,489,059	\$ 1,909,059	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,600,000	2,600,000	39
40	Mortgage Payable		10,608,631	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)	\$ 2,600,000	\$ 13,208,631	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,089,059	\$ 15,117,690	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,416,628	\$ 36,064	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,505,687	\$ 15,153,754	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 736,696	1
2	Restatements (describe):		2
3	Distributions to Owners	(1,100,000)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (363,304)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,779,933	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) Rounding	(1)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,779,932	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)	\$ 1,416,628	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BELHAVEN NURSING & REHABILITATION C # 0048215 Report Period Beginning: 1/1/08Ending: 12/31/08**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 12,027,280	1
2	Discounts and Allowances for all Levels	(647,926)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,379,354	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,225,917	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,225,917	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	190,786	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	20,341	19
20	Radiology and X-Ray	5,642	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 216,769	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,175	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,175	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Vending</u>	2,845	28
28a	<u>Miscellaneous</u>	(17,555)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (14,710)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,809,505	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,915,932	31
32	Health Care	5,221,684	32
33	General Administration	1,776,145	33
B. Capital Expense			
34	Ownership	1,763,871	34
C. Ancillary Expense			
35	Special Cost Centers	230,610	35
36	Provider Participation Fee	121,330	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,029,572	40
41	Income before Income Taxes (line 30 minus line 40)**	1,779,933	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,779,933	43

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

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

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

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

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

0048215

Report Period Beginning: **1/1/08**

Ending:

12/31/08

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,015	2,186	\$ 93,088	\$ 42.58	1
2	Assistant Director of Nursing					2
3	Registered Nurses	23,581	25,214	766,840	30.41	3
4	Licensed Practical Nurses	51,319	55,241	1,342,523	24.30	4
5	CNAs & Orderlies	133,222	145,546	1,417,484	9.74	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	13,176	14,328	130,467	9.11	9
10	Activity Assistants					10
11	Social Service Workers	5,754	6,427	96,865	15.07	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	29,655	32,680	382,209	11.70	15
16	Dishwashers					16
17	Maintenance Workers	3,901	4,256	64,485	15.15	17
18	Housekeepers	24,740	27,874	279,199	10.02	18
19	Laundry	13,045	14,552	152,762	10.50	19
20	Administrator	2,054	2,278	89,378	39.24	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,353	10,526	206,868	19.65	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)					33
34	TOTAL (lines 1 - 33)	311,815	341,108	\$ 5,022,168 *	\$ 14.72	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	142	\$ 4,981	10-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	390	19,477	10-3	38
39	Pharmacist Consultant	80	4,000	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	159	5,569	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	771	\$ 34,027		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
BEN FRIEDMAN	ADMIN	0	\$ 65,201	Workers' Compensation Insurance	\$ 102,138	IDPH License Fee	\$	
MICHAEL PERL	ADMIN	0	24,177	Unemployment Compensation Insurance	120,079	Advertising: Employee Recruitment		
				FICA Taxes	381,903	Health Care Worker Background Check		
				Employee Health Insurance	91,862	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		LICENSE FEES/DUES	2,447	
				UNIFORMS	3,916			
				PHYSICAL	975			
				EMPLOYEE EXPENSE	75,841			
				LIFE INSURANCE	27,932	Less: Public Relations Expense	()	
				PENSION	110	Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1)				TOTAL (agree to Schedule V,			TOTAL (agree to Sch. V,	
(List each licensed administrator separately.)				line 22, col.8)			line 20, col. 8)	
\$ 89,378				\$ 804,756			\$ 2,447	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description	Amount			Description	Line #	Amount	Description	Amount
	\$					\$	Out-of-State Travel	\$
							In-State Travel	
							AUTO ALLOWANCE	19,328
							MILEAGE	8,858
							Seminar Expense	
							BUSINESS SEMINAR EXPENSE	3,228
							Entertainment Expense	()
							(agree to Sch. V,	
TOTAL (agree to Schedule V, line 17, col. 3)				TOTAL			TOTAL (agree to Sch. V,	
(Attach a copy of any management service agreement)				\$			line 24, col. 8)	
\$				\$			\$ 31,414	
C. Professional Services								
Vendor/Payee	Type	Amount						
SWANSON, MARTIN, BELL	LEGAL	\$ 991						
MEYER MAGENCE	LEGAL	3,045						
STONE, MCGUIRE & SIEGEL	LEGAL	310						
NY BOYS MANAGEMENT	LEGAL	2,902						
BRADLEY & ASSOCIATES	ACCOUNTING	12,330						
JOHNSON, GOLDBERG	ACCOUNTING	1,000						
NY BOYS MANAGEMENT	MGMT. CO	263,925						
TOTAL (agree to Schedule V, line 19, column 3)								
(If total legal fees exceed \$5,000, attach copy of invoices.)								
\$ 284,502								

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2005	6 FY2006	7 FY2007	8 FY2008	9 FY2009	10 FY2010	11 FY2011	12 FY2012	13 FY2013
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 BELHAVEN NURSING & REHABILITATION CENTER

0048215

Report Period Beginning: 1/1/08

Ending: 12/31/08

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 action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 5 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 66,847 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. \$ 121,330
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? 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 \$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.

SEE ACCOUNTANTS' COMPILATION REPORT