

Facility Name & ID Number Maryhaven Nursing & Rehabilitation

0044768 Report Period Beginning: 07/01/07 Ending: 06/30/08

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 N/A

	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	135	Skilled (SNF)	135	49,410	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	135	TOTALS	135	49,410	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	552	714	7,071	8,337	8
9	SNF/PED					9
10	ICF	16,838	14,166	152	31,156	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,390	14,880	7,223	39,493	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.93%

D. How many bed-hold days during this year were paid by the Department? None (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 03/01/2000

J. Was the facility purchased or leased after January 1, 1978?
YES Date 03/01/00 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 135 and days of care provided 6,857

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 06/30/08 Fiscal Year: 06/30/08

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

Facility Name & ID Number Maryhaven Nursing & Rehabilitation # 0044768 Report Period Beginning: 07/01/07 Ending: 06/30/08

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	382,857	48,450	15,124	446,431		446,431		446,431		1
2	Food Purchase		264,531		264,531		264,531	(23,053)	241,478		2
3	Housekeeping	151,699	86		151,785		151,785		151,785		3
4	Laundry	130,074	61,190	335	191,599		191,599		191,599		4
5	Heat and Other Utilities			221,288	221,288		221,288		221,288		5
6	Maintenance	89,589	22,813	133,765	246,167		246,167		246,167		6
7	Other (specify):*										7
8	TOTAL General Services	754,219	397,070	370,512	1,521,801		1,521,801	(23,053)	1,498,748		8
	B. Health Care and Programs										
9	Medical Director			21,000	21,000		21,000		21,000		9
10	Nursing and Medical Records	2,434,450	89,732	31,835	2,556,017		2,556,017		2,556,017		10
10a	Therapy	173,817	6,127	88,273	268,217		268,217		268,217		10a
11	Activities	175,631	6,565	7,085	189,281		189,281		189,281		11
12	Social Services	71,122			71,122		71,122		71,122		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,855,020	102,424	148,193	3,105,637		3,105,637		3,105,637		16
	C. General Administration										
17	Administrative	77,134		576,918	654,052		654,052	(576,918)	77,134		17
18	Directors Fees										18
19	Professional Services										19
20	Dues, Fees, Subscriptions & Promotions			16,493	16,493		16,493		16,493		20
21	Clerical & General Office Expenses	251,359	50,942	1,238	303,539		303,539	526,152	829,691		21
22	Employee Benefits & Payroll Taxes			1,314,543	1,314,543		1,314,543	171,421	1,485,964		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,689	1,689		1,689		1,689		24
25	Other Admin. Staff Transportation			5,072	5,072		5,072		5,072		25
26	Insurance-Prop.Liab.Malpractice			185,513	185,513		185,513		185,513		26
27	Other (specify):*										27
28	TOTAL General Administration	328,493	50,942	2,101,466	2,480,901		2,480,901	120,655	2,601,556		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,937,732	550,436	2,620,171	7,108,339		7,108,339	97,602	7,205,941		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 Maryhaven Nursing & Rehabilitation

#0044768

Report Period Beginning:

07/01/07

Ending:

06/30/08

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			439,983	439,983		439,983	64,365	504,348			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							1,217	1,217			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			46,379	46,379		46,379		46,379			35
36	Other (specify):*											36
37	TOTAL Ownership			486,362	486,362		486,362	65,582	551,944			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		730,222		730,222		730,222		730,222			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			74,115	74,115		74,115		74,115			42
43	Other (specify):* Nonallowable Cost			18,358	18,358		18,358	(18,358)				43
44	TOTAL Special Cost Centers		730,222	92,473	822,695		822,695	(18,358)	804,337			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,937,732	1,280,658	3,199,006	8,417,396		8,417,396	144,826	8,562,222			45

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

**See schedule of adjustments attached at end of cost report.

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				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(18,358)	43		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(44,813)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (63,171)		\$	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)	207,997		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 207,997		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 144,826		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

Maryhaven Nursing & Rehabilitation

ID# 0044768

Report Period Beginning: 07/01/07

Ending: 06/30/08

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Interest Income Offset	\$ (10,596)	30	1
2	Miscellaneous Revenue Offset	(11,164)	21	2
3	Nonresident Meal Revenue Offset	(23,053)	2	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	(44,813)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Maryhaven Nursing & Rehabilitation# 0044768

Report Period Beginning:

07/01/07

Ending:

06/30/08

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(23,053)	0	0	0	0	0	0	0	0	0	0	(23,053)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(23,053)	0	0	0	0	0	0	0	0	0	0	(23,053)	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	(576,918)	0	0	0	0	0	0	0	0	0	(576,918)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(11,164)	537,316	0	0	0	0	0	0	0	0	0	526,152	21
22	Employee Benefits & Payroll Taxes	0	171,421	0	0	0	0	0	0	0	0	0	171,421	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(11,164)	131,819	0	120,655	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(34,217)	131,819	0	97,602	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Maryhaven Nursing & Rehabilitation# 0044768

Report Period Beginning:

07/01/07

Ending:

06/30/08

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	(10,596)	64,365	0	0	0	0	0	0	0	0	0	53,769	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	11,813	0	0	0	0	0	0	0	0	0	11,813	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(10,596)	76,178	0	65,582	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):*	(18,358)	0	0	0	0	0	0	0	0	0	0	(18,358)	43
44	TOTAL Special Cost Centers	(18,358)	0	0	0	0	0	0	0	0	0	0	(18,358)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(63,171)	207,997	0	144,826	45								

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
<u>Resurrection Health Care</u>	<u>100</u>	<u>See attached</u>		<u>See attached</u>		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	<u>21 Clerical & data processing</u>	\$	<u>Resurrection Health Care</u>	<u>100.00%</u>	<u>\$ 537,316</u>	<u>\$ 537,316</u>	<u>1</u>
2	V	<u>22 Employee benefits</u>		<u>Resurrection Health Care</u>	<u>100.00%</u>	<u>171,421</u>	<u>171,421</u>	<u>2</u>
3	V	<u>30 Depreciation</u>		<u>Resurrection Health Care</u>	<u>100.00%</u>	<u>64,365</u>	<u>64,365</u>	<u>3</u>
4	V	<u>32 Interest Expense</u>		<u>Resurrection Health Care</u>	<u>100.00%</u>	<u>11,813</u>	<u>11,813</u>	<u>4</u>
5	V							<u>5</u>
6	V	<u>17 Intercompany expense</u>	<u>576,918</u>	<u>Resurrection Health Care</u>	<u>100.00%</u>		<u>(576,918)</u>	<u>6</u>
7	V	<u>39 Intercompany pharmacy</u>	<u>730,222</u>	<u>Resurrection Health Care</u>	<u>100.00%</u>	<u>730,222</u>		<u>7</u>
8	V							<u>8</u>
9	V							<u>9</u>
10	V							<u>10</u>
11	V							<u>11</u>
12	V							<u>12</u>
13	V							<u>13</u>
14	Total		\$ 1,307,140			\$ 1,515,137	\$ * 207,997	14

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

Facility Name & ID Number Maryhaven Nursing & Rehabilitation # 0044768 Report Period Beginning: 07/01/07 Ending: 06/30/08

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									\$		1
2	See Attached Page 7A										2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maryhaven Nursing & Rehabilitation

0044768

Report Period Beginning:

07/01/07

Ending: 06/30/08

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 Resurrection Health Care/Medical Center
 Street Address 7435 W. Talcott
 City / State / Zip Code Chicago, IL 60631
 Phone Number (773) 774-8000
 Fax Number (773) 594-7488

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	21	Clerical & data processing			\$	\$		\$ 537,316	1
2	22	Employee benefits						171,421	2
3	30	Depreciation						64,365	3
4	32	Interest Expense						11,813	4
5									5
6	39	Intercompany Pharmacy						730,222	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				\$	\$		\$ 1,515,137	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maryhaven Nursing & Rehabilitation # 0044768 Report Period Beginning: 07/01/07 Ending: 06/30/08

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	N/A																			
2																				
3																				
4																				
5																				
Working Capital																				
6	N/a																			
7																				
8																				
9	TOTAL Facility Related																			
B. Non-Facility Related*																				
10	N/A																			
11																				
12																				
13																				
14	TOTAL Non-Facility Related																			
15	TOTALS (line 9+line14)																			

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

* 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.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2007 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 2008 report. (Detail and explain your calculation of this accrual on the lines below.)

\$ **4**

5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C.

(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)

\$ **5**

6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.

TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)

\$ **6**

7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.

\$ **7**

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	<u> </u>	8
	2004	<u> </u>	9
	2005	<u> </u>	10
	2006	<u> </u>	11
	2007	<u> </u>	12

FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2007	\$ <u> </u> 13
14	PLUS APPEAL COST FROM LINE 5	\$ <u> </u> 14
15	LESS REFUND FROM LINE 6	\$ <u> </u> 15
16	AMOUNT TO USE FOR RATE CALCULATION	\$ <u> </u> 16

Facility is a not-for-profit and does not pay real estate taxes.

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 Maryhaven Nursing & Rehabilitation COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0044768

CONTACT PERSON REGARDING THIS REPORT Thomas W. Groenwald

TELEPHONE (773) 594-7837 FAX #: (773) 594-5867

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. _____	_____	\$ _____	\$ _____
2. <u>Facility is a not-for-profit and does not pay real estate taxes.</u>	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES N/A 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 Maryhaven Nursing & Rehabilitation

0044768

Report Period Beginning:

07/01/07

Ending:

06/30/08

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 83,762 B. General Construction Type: Exterior Brick Frame _____ Number of Stories One

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>		<u>2000</u>	<u>\$ 3,000,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 3,000,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

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	135	2000	1961	\$ 5,932,922	\$ 197,764	30	\$ 197,764	\$	\$ 1,649,557
5		2006		2,137	142	15	142		213
6									
7									
8									
Improvement Type**									
9	Facility		2000	7,995		10			
10	Plumbing		2001	7,539		10			
11	Architect Fees		2001	3,299		20			
12	Architect Fees		2001	3,097		20			
13	Landscape Architect		2001	1,478		20			
14	Topographic mapping		2001	9,386		20			
15	Cooler Repair		2000	766		20			
16	Hot water softener		2001	1,150		20			
17	Freezer repair		2001	974		20			
18	HVAC		2001	563		20			
19	HVAC		2001	872		20			
20	Fire panel		2001	775		20			
21	Mechanical repairs		2001	3,565		20			
22	Cooler repair		2001	4,121		20			
23	Water chiller		2000	49,020		15			
24	Professional services, renovation		2001	20,422		10			
25	Landscape Architect		2001	11,815		20			
26	Floor painting		2001	499		20			
27	Stainless steel kick plate		2001	893		20			
28	Dry wall guard		2001	775		20			
29	Windows		2001	994		20			
30	Heating & cooling		2002	623		20			
31	Swing door gaskets		2002	599		20			
32	Remove work duct		2002	971		20			
33	Air coil		2002	951		20			
34	Reconnect work duct		2002	643		20			
35	Water main repair		2001	1,880		20			
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 Maryhaven Nursing & Rehabilitation

0044768

Report Period Beginning:

07/01/07

Ending:

06/30/08

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	Electrical	2002	\$ 861	\$		\$	\$	\$	37
38	Lock hardware	2002	673						38
39	Lock hardware	2002	698						39
40	Steel Craft metal door	2002	713						40
41	Tile	2002	1,078						41
42	Sentronics	2002	1,182						42
43	Asbestos abatement	2001	9,820						43
44	Architect services & entry, hall, library	2001	155,084						44
45	Landscaping Architecture	2002	11,193						45
46	Telephone re-wiring	2001	2,411						46
47	Boilers	2002	59,639						47
48	Boilers	2001	21,400						48
49	Boilers	2002	64,768						49
50	Construction, entry, hall, library	2002	1,279,284						50
51	Boiler replacement	2003	169,727						51
52	Landscaping Architecture	2003	26,038						52
53	Voice cable	2003	1,137						53
54	Piping	2003	91,907						54
55	Water retention	2003	5,071						55
56	Air compressor	2003	12,077						56
57									57
58	Phase II Site Drainage - 7/25/03	2003	2,649	177	15	177		528	58
59	Prof. Engin. Civil Services	2003	994	99	10	99		299	59
60	Repair Check Valve in Circuit #2	2003	5,014	501	10	501		1,505	60
61	Private Office LLB - 9	2003	1,428	95	15	95		287	61
62	Phase II Site Drain - Pr.S. 9/27/03 - 10/31/03	2003	362	24	15	24		72	62
63	Install side steam filter system	2003	2,695	270	10	270		810	63
64	Install heat-timer control system	2003	6,980	698	10	698		2,094	64
65	Install 4 plastic laminate gates at nurses stations	2004	1,760	108	15	108		344	65
66	Installation of 67 fire dampers	2004	20,560	2,056	10	2,056		6,168	66
67	Installation of new phone & paging system	2004	10,592	1,059	10	1,059		3,179	67
68	Nortel Norstar voicemail call pilot 150 new	2004	3,000	600	5	600		1,800	68
69	Installation of new LCN 7780 series control	2004	2,383	238	10	238		714	69
70	TOTAL (lines 4 thru 69)		\$ 8,043,902	\$ 203,831		\$ 203,831	\$	\$ 1,667,570	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Maryhaven Nursing & Rehabilitation

0044768

Report Period Beginning:

07/01/07

Ending:

06/30/08

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		\$ 8,043,902	\$ 203,831		\$ 203,831	\$	\$ 1,667,570	1
2	Labor & material to install 2 new hot water boilers	2004	46,411	4,641	10	4,641		20,885	2
3									3
4	Excavation & Placement of concrete sidewalk	2005	3,960	264	15	264		924	4
5	Seal coat & restripe, pothole patching, crackseal	2005	5,300	530	10	530		1,855	5
6									6
7									7
8	Boiler Maintenance	2005	1,930	97	20	97		362	8
9	Building and renovation project costs	2005	2,037	204	10	204		714	9
10	Vinyl Tile w/border	2005	19,137	1,914	10	1,914		6,699	10
11	Replace 6" copper tee w/ 6" elbow	2005	2,220	222	10	222		777	11
12	Replace valve, replace all 6" pipe w/ 3" pipe	2005	7,555	756	10	756		2,646	12
13	Install push button, access back to back keySPACE	2005	2,769	396	7	396		1,386	13
14	Sprinklers to new drop ceiling	2005	950	190	5	190		665	14
15									15
16									16
17	Placement of sidewalks & concrete pad	2006	3,450	230	15	230		575	17
18	Placement of concrete pad at dryer vent	2006	1,500	100	15	100		250	18
19	Flooring	2006	8,136	814	10	814		2,035	19
20	Electrical installation & connection	2006	6,314	789	8	789		1,973	20
21	Installation of new duct work	2006	10,000	667	15	667		1,667	21
22	Base & wall mount cabinetry for PT room	2006	6,123	408	15	408		1,020	22
23	Fire Sprinkler/13 concealed heads from exist. 1/2"	2006	3,640	243	15	243		607	23
24	Pipe evaporative condensor w/Trane	2006	15,270	1,527	10	1,527		3,818	24
25	Landscaping Architecture	2006	3,500	438	8	438		1,001	25
26	Rewire emergency power circuit	2006	4,012	802	5	802		2,552	26
27	Repairs to walk in freezer, compressor & milk cooler	2006	1,803	120	15	120		788	27
28									28
29	Excavation & Removal of Grass & Dirt	2006	6,550	935	7	935		1,403	29
30	Install Electrically connect illum.in.sign	2006	6,347	908	7	908		1,361	30
31	Prep and pain front entrance	2006	4,885	698	7	698		1,047	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,217,701	\$ 221,724		\$ 221,724	\$	\$ 1,724,580	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 8,217,701	\$ 221,724		\$ 221,724	\$	\$ 1,724,580	1
2	Hallway lights lamps	2006	19,200	2,400	8	2,400		3,600	2
3	Run Electrical Power for new sign	2006	4,294	537	8	537		805	3
4	Installation of Brick and concrete sign pillar	2007	2,310	289	8	289		433	4
5									5
6	Sump Drains & Installation	2008	73,448	1,836	20	1,836		1,836	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14	Home office allocation					64,365	64,365		14
15	Financial Statement Depreciation			125,356		125,356		988,958	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	TOTAL (lines 1 thru 33)		\$ 8,316,953	\$ 352,142		\$ 416,507	\$ 64,365	\$ 2,720,212	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,190,405	\$ 77,895	\$ 77,895	\$	5-20	\$ 956,462	71
72	Current Year Purchases	203,147	9,946	9,946		5-25	9,946	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,393,552	\$ 87,841	\$ 87,841	\$		\$ 966,408	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	Resident Care	Ford E350 Van	2001	\$ 5,030	\$	\$	\$	5	\$ 5,030	76
77										77
78										78
79										79
80	TOTALS			\$ 5,030	\$	\$	\$		\$ 5,030	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)	\$ 12,715,535	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 439,983	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 504,348	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 64,365	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,691,650	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			N/A		88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94		N/A	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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions							4
5					N/A			5
6								6
7	TOTAL				\$ _____			7

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

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

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

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

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ 46,379 Description: Copiers 14,391; Postage Meter 1,873; Satellite equipment 3,632; Special Mattresses/Beds 26,483

(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			N/A		18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____ /2009 \$ _____

13. _____ /2010 \$ _____

14. _____ /2011 \$ _____

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

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

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?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of the facility to hire only Certified Nursing Aides. 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		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(1,2,3)	1710 hrs	\$ 64,856	701	\$ 39,370	\$ 2,286	2,411	\$ 106,512	1
2	Licensed Speech and Language Development Therapist	10A(1,2,3)	404 hrs	15,303	168	11,280	539	572	27,122	2
3	Licensed Recreational Therapist		hrs		712	37,623		712	37,623	3
4	Licensed Physical Therapist	10A(1,2,3)	2470 hrs	93,659			3,302	2,470	96,960	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				730,222		730,222	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	TOTAL			\$ 173,818	1,581	\$ 88,273	\$ 736,349	6,165	\$ 998,439	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 Maryhaven Nursing & Rehabilitation

0044768

Report Period Beginning: 07/01/07

Ending:

06/30/08

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/08

(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	\$ 1,044,270	\$ 1,044,270	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 464,818)	942,528	942,528	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	3,893	3,893	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,990,691	\$ 1,990,691	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	2,384,698	3,000,000	13
14	Buildings, at Historical Cost	7,839,180	5,935,059	14
15	Leasehold Improvements, at Historical Cost	83,952	2,381,894	15
16	Equipment, at Historical Cost	1,791,765	1,398,582	16
17	Accumulated Depreciation (book methods)	(3,691,809)	(3,691,650)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	69,720	69,720	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(67,396)	(67,396)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 8,410,110	\$ 9,026,209	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,400,801	\$ 11,016,900	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 123,038	\$ 123,038	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due From Related Entities	2,086,142	2,086,142	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,209,180	\$ 2,209,180	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,209,180	\$ 2,209,180	46
47	TOTAL EQUITY(page 18, line 24)	\$ 8,191,621	\$ 8,807,720	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 10,400,801	\$ 11,016,900	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 8,098,377	1
2	Restatements (describe):		2
3	Prior Period Adjustment	410,462	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 8,508,839	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(317,218)	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)	\$ (317,218)	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)	\$ 8,191,621	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 8,380,776	1
2	Discounts and Allowances for all Levels	(2,270,872)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,109,904	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,012,788	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,012,788	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	23,053	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	859,649	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,305	19
20	Radiology and X-Ray	32,827	20
21	Other Medical Services	6,058	21
22	Laundry	28,478	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 951,370	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	10,596	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 10,596	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transfers from Temporary Restricted Funds</u>	4,356	28
28a	<u>Miscellaneous Revenue</u>	11,164	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 15,520	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,100,178	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,521,801	31
32	Health Care	3,105,637	32
33	General Administration	2,480,901	33
	B. Capital Expense		
34	Ownership	486,362	34
	C. Ancillary Expense		
35	Special Cost Centers	748,580	35
36	Provider Participation Fee	74,115	36
	D. Other Expenses (specify):		
37			37
38			38
39		b	39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,417,396	40
41	Income before Income Taxes (line 30 minus line 40)**	(317,218)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (317,218)	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 Maryhaven Nursing & Rehabilitation

0044768

Report Period Beginning: 07/01/07

Ending: 06/30/08

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	1,674	1,971	\$ 85,904	\$ 43.58	1
2	Assistant Director of Nursing	1,766	2,080	73,814	35.49	2
3	Registered Nurses	25,828	29,122	987,162	33.90	3
4	Licensed Practical Nurses	5,897	6,991	175,674	25.13	4
5	CNAs & Orderlies	59,321	67,822	945,469	13.94	5
6	CNA Trainees					6
7	Licensed Therapist	4,070	4,584	173,817	37.92	7
8	Rehab/Therapy Aides	5,341	5,978	74,663	12.49	8
9	Activity Director	1,880	2,072	45,134	21.78	9
10	Activity Assistants	6,026	6,859	76,239	11.12	10
11	Social Service Workers	2,785	3,160	71,122	22.51	11
12	Dietician	592	616	12,726	20.66	12
13	Food Service Supervisor	3,536	4,164	92,301	22.17	13
14	Head Cook	7,131	8,307	112,574	13.55	14
15	Cook Helpers/Assistants	14,375	17,074	165,256	9.68	15
16	Dishwashers					16
17	Maintenance Workers	4,014	4,401	89,589	20.36	17
18	Housekeepers	13,078	15,512	151,699	9.78	18
19	Laundry	9,449	11,023	130,074	11.80	19
20	Administrator	1,734	1,840	77,134	41.92	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,291	13,617	251,359	18.46	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 C: Care Plan Coord	2,556	2,742	91,764	33.47	32
33	Other(specify) <u>Religious Wages</u>	1,996	2,259	54,258	24.02	33
34	TOTAL (lines 1 - 33)	185,340	212,194	\$ 3,937,732 *	\$ 18.56	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			35
36	Medical Director	Monthly	21,000	9(3) 36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant			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			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)		\$ 21,000	49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	289	\$ 14,619	10(3) 50
51	Licensed Practical Nurses	259	9,792	10(3) 51
52	Certified Nurse Assistants/Aides	333	7,424	10(3) 52
53	TOTAL (lines 50 - 52)	881	\$ 31,835	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	
Sara Szumski	Administrator	0	\$ 77,134	Workers' Compensation Insurance	\$ 53,485	IDPH License Fee	\$ 2,985	
				Unemployment Compensation Insurance	8,684	Advertising: Employee Recruitment		
				FICA Taxes	283,404	Health Care Worker Background Check		
				Employee Health Insurance	699,889	(Indicate # of checks performed 130)	2,082	
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		IL Council of LTC dues	5,744	
				Retirement	229,072	Life Services Network dues	2,625	
				Disability	22,374	Miscellaneous Dues/Subscriptions	3,057	
				Employee Morale/Recognition	17,635			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 77,134			Less: Public Relations Expense	()	
B. Administrative - Other						Non-allowable advertising	()	
Description			Amount	Home Office Allocation	171,421	Yellow page advertising	()	
Management Fee (eliminated in column 7)			\$ 576,918					
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 1,485,964	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 16,493	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 576,918	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
None			\$			\$	Out-of-State Travel	\$
				N/A			In-State Travel	
							Seminar Expense	1,689
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 1,689

* 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	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4		N/A											
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 Maryhaven Nursing & Rehabilitation# 0044768

Report Period Beginning:

07/01/07

Ending:

06/30/08**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. LSNI - 2625; Illinois Council LTC-5744
- (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? 15 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 12,587 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. \$ 74,115
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 23,053
- (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? None
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- 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? N/A**
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? Yes
Firm Name: KPMG LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit not yet complete
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees