



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

# **0048215** Report Period Beginning: **1/1/09** Ending: **12/31/09**

**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	80,665	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	80,665	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	60,247	3,149	10,654	74,050	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	60,247	3,149	10,654	74,050	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.80%**

**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 7,259

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: 12/31/09 Fiscal Year: 12/31/09

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **BELHAVEN NURSING & REHABILITATION** # **0048215** Report Period Beginning: **1/1/09** Ending: **12/31/09**

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

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjustments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	354,316	40,343	10,567	405,226		405,226	1,636	406,862		1
2	Food Purchase		387,960		387,960		387,960		387,960		2
3	Housekeeping	284,028	51,881		335,909		335,909		335,909		3
4	Laundry	173,460	22,770		196,230		196,230		196,230		4
5	Heat and Other Utilities			324,295	324,295		324,295	460	324,755		5
6	Maintenance	64,250	20,879	80,268	165,397		165,397	(2,718)	162,679		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>876,054</b>	<b>523,833</b>	<b>415,130</b>	<b>1,815,017</b>		<b>1,815,017</b>	<b>(622)</b>	<b>1,814,395</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	3,686,146	552,636	23,708	4,262,490		4,262,490	10,825	4,273,315		10
10a	Therapy			611,246	611,246		611,246		611,246		10a
11	Activities	144,300	22,270		166,570		166,570		166,570		11
12	Social Services	62,212		5,027	67,239		67,239		67,239		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <b>Pharmacy Consult.</b>			2,500	2,500		2,500		2,500		15
16	<b>TOTAL Health Care and Programs</b>	<b>3,892,658</b>	<b>574,906</b>	<b>654,481</b>	<b>5,122,045</b>		<b>5,122,045</b>	<b>10,825</b>	<b>5,132,870</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	91,716			91,716		91,716		91,716		17
18	Directors Fees										18
19	Professional Services			291,325	291,325		291,325	(266,832)	24,493		19
20	Dues, Fees, Subscriptions & Promotions			6,364	6,364		6,364		6,364		20
21	Clerical & General Office Expenses	170,513	65,823	42,505	278,841		278,841	81,237	360,078		21
22	Employee Benefits & Payroll Taxes			741,250	741,250		741,250	24,560	765,810		22
23	Inservice Training & Education										23
24	Travel and Seminar			33,295	33,295		33,295	6,321	39,616		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			266,964	266,964		266,964	64,492	331,456		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>262,229</b>	<b>65,823</b>	<b>1,381,703</b>	<b>1,709,755</b>		<b>1,709,755</b>	<b>(90,222)</b>	<b>1,619,533</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>5,030,941</b>	<b>1,164,562</b>	<b>2,451,314</b>	<b>8,646,817</b>		<b>8,646,817</b>	<b>(80,019)</b>	<b>8,566,798</b>		<b>29</b>

\*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.

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			110,753	110,753		110,753	119,890	230,643			30
31	Amortization of Pre-Op. & Org.							307,019	307,019			31
32	Interest			74,230	74,230		74,230	631,941	706,171			32
33	Real Estate Taxes							363,886	363,886			33
34	Rent-Facility & Grounds			1,680,000	1,680,000		1,680,000	(1,679,118)	882			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,864,983	1,864,983		1,864,983	(256,382)	1,608,601			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		224,179		224,179		224,179		224,179			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			120,998	120,998		120,998		120,998			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		224,179	120,998	345,177		345,177		345,177			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	5,030,941	1,388,741	4,437,295	10,856,977		10,856,977	(336,401)	10,520,576			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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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	(42,565)	30		9
10	Interest and Other Investment Income	(1,002)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(170)	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	(5,388)	21		18
19	Entertainment				19
20	Contributions	(16,000)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(4,459)	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	(7,336)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (76,920)		\$	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	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule	(259,481)	Various	35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (259,481)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (336,401)		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
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

<b>BHF USE ONLY</b>							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

BELHAVEN NURSING & REHABILITATION CENTER

ID# 0048215

Report Period Beginning: 1/1/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	VENDING INCOME	\$ (2,718)	6	1
2	MEDICAL RECORDS INCOME	(3,288)	10	2
3	MISCELLANEOUS INCOME	(1,330)	21	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(7,336)		49

## STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

1/1/09

Ending:

12/31/09

## 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	(170)	1,806	0	0	0	0	0	0	0	0	0	1,636	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	460	0	0	0	0	0	0	0	0	0	460	5
6	Maintenance	(2,718)	0	0	0	0	0	0	0	0	0	0	(2,718)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(2,888)</b>	<b>2,266</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(622)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(3,288)	14,113	0	0	0	0	0	0	0	0	0	10,825	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	<b>TOTAL Health Care and Programs</b>	<b>(3,288)</b>	<b>14,113</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>10,825</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(266,832)	0	0	0	0	0	0	0	0	0	(266,832)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(27,177)	108,414	0	0	0	0	0	0	0	0	0	81,237	21
22	Employee Benefits & Payroll Taxes	0	24,560	0	0	0	0	0	0	0	0	0	24,560	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	6,321	0	0	0	0	0	0	0	0	0	6,321	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	561	63,931	0	0	0	0	0	0	0	0	64,492	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(27,177)</b>	<b>(126,976)</b>	<b>63,931</b>	<b>0</b>	<b>(90,222)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(33,353)</b>	<b>(110,597)</b>	<b>63,931</b>	<b>0</b>	<b>(80,019)</b>	<b>29</b>							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BELHAVEN NURSING & REHABILITATION CENTER # 0048215 Report Period Beginning: 1/1/09 Ending: 12/31/09

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 TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	(42,565)	162,455	0	0	0	0	0	0	0	0	0	119,890	30
31	Amortization of Pre-Op. & Org.	0	0	307,019	0	0	0	0	0	0	0	0	307,019	31
32	Interest	(1,002)	0	632,943	0	0	0	0	0	0	0	0	631,941	32
33	Real Estate Taxes	0	363,886	0	0	0	0	0	0	0	0	0	363,886	33
34	Rent-Facility & Grounds	0	(1,679,118)	0	0	0	0	0	0	0	0	0	(1,679,118)	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	<b>TOTAL Ownership</b>	<b>(43,567)</b>	<b>(1,152,777)</b>	<b>939,962</b>	<b>0</b>	<b>(256,382)</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(76,920)</b>	<b>(1,263,374)</b>	<b>1,003,893</b>	<b>0</b>	<b>(336,401)</b>	<b>45</b>							

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
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	10 NURSING	\$ 24,000	NEW YORK BOYS MANAGEMENT	46.25%	\$ 38,113	\$ 14,113	1
2	V	1 DIETARY	14,150	NEW YORK BOYS MANAGEMENT		15,956	1,806	2
3	V	5 UTILITIES		NEW YORK BOYS MANAGEMENT		460	460	3
4	V	21 OFFICE EXPENSE	9,170	NEW YORK BOYS MANAGEMENT		117,447	108,277	4
5	V	19 PROFESSIONAL SERVICES	271,215	NEW YORK BOYS MANAGEMENT		4,383	(266,832)	5
6	V	22 LIFE INSURANCE	1,300	NEW YORK BOYS MANAGEMENT		25,860	24,560	6
7	V	24 AUTO/TRAVEL EXPENSE	182	NEW YORK BOYS MANAGEMENT		6,503	6,321	7
8	V	34 FACILITY/GROUNDS		NEW YORK BOYS MANAGEMENT		882	882	8
9	V	26 INSURANCE		NEW YORK BOYS MANAGEMENT		561	561	9
10	V	21 OFFICE EXPENSE		BELHAVEN REALTY, LLC		137	137	10
11	V	30 DEPRECIATION		BELHAVEN REALTY, LLC		162,455	162,455	11
12	V	33 REAL ESTATE TAXES		BELHAVEN REALTY, LLC		363,886	363,886	12
13	V	34 RENT	1,680,000	BELHAVEN REALTY, LLC			(1,680,000)	13
14	Total		\$ 2,000,017			\$ 736,643	\$ * (1,263,374)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	26 LIABILITY INSURANCE	\$	BELHAVEN REALTY, LLC		\$ 63,931	\$ 63,931	15
16	V	32 INTEREST		BELHAVEN REALTY, LLC		632,943	632,943	16
17	V	31 AMORTIZATION		BELHAVEN REALTY, LLC		307,019	307,019	17
18	V							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		\$			\$ 1,003,893	\$ * 1,003,893	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **BELHAVEN NURSING & REHABILITAT** # **0048215** Report Period Beginning: **1/1/09** Ending: **12/31/09**

**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											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								<b>TOTAL</b>	\$		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

**ATTACHMENT #1**

OWNERS

OTHER RELATED BUSINESS ENTITIES

NAME	OWNERSHIP %	NAME	CITY	TYPE OF BUSINESS
MICHAEL BLISKO	35.000%	NEW YORK BOYS MANAGEMENT	CROWN POINT, IN	MANAGEMENT CO.
MOISHE GUBIN	35.000%			
A&F GENERAL PARTNERSHIP	<u>30.000%</u>			
	<u>100.000%</u>			

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

Facility Name & ID Number BELHAVEN NURSING & REHABILITATION CENTER # 0048215 Report Period Beginning: 1/1/09 Ending: 12/31/09

**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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **BELHAVEN NURSING & REHABILITATI** # **0048215** Report Period Beginning: **1/1/09** Ending: **12/31/09**

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	HUD		X	MORTGAGE	\$105,131.00	10/24/08	\$ 10,616,000	\$ 10,516,046	10/24/2043	5.9900	\$ 632,943	1								
2												2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6	MIDWEST BANK & TRUST CO.		X	WORKING CAPITAL	NONE	7/11/06	2,800,000	950,000	6/1/2010	8.2500	74,230	6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>				\$105,131.00		\$ 13,416,000	\$ 11,466,046			\$ 707,173	9								
<b>B. Non-Facility Related*</b>																				
10												10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 13,416,000	\$ 11,466,046			\$ 707,173	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.)

**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

1. Real Estate Tax accrual used on 2008 report.	\$	<b>368,192</b>	<b>1</b>
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.)	\$	<b>368,116</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).	\$	<b>(76)</b>	<b>3</b>
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<b>363,962</b>	<b>4</b>
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$		<b>5</b>
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	<b>363,886</b>	<b>7</b>

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	<b>2004</b>		<b>8</b>
	<b>2005</b>	<b>417,369</b>	<b>9</b>
	<b>2006</b>	<b>368,191</b>	<b>10</b>
	<b>2007</b>	<b>364,216</b>	<b>11</b>
	<b>2008</b>	<b>368,116</b>	<b>12</b>

<b>FOR BHF USE ONLY</b>			
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2008	\$	<b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**NOTES:**

- Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
- 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



Facility Name & ID Number BELHAVEN NURSING & REHABILITATION CENTER

# 0048215 Report Period Beginning:

1/1/09 Ending:

12/31/09

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).

Blank lines for listing other business entities.

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.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a numbered column. Row 1: Nursing Home, 4/11/2006, \$100,000, 1. Row 2: 2. Row 3: TOTALS, \$100,000, 3.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number BELHAVEN NURSING &amp; REHABILITATION CENTER

# 0048215

Report Period Beginning:

1/1/09

Ending:

12/31/09

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	221	2006		\$ 5,500,000	\$ 141,026	39	\$ 141,026	\$	\$ 493,591	4
5										5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	Dish Machine	12/8/2006		1,875	48	39	48		192	9
10	Wanderguard Security Camera	7/25/2006		37,000	949	39	949		3,796	10
11	Elevator Items	3/2/2005		3,495	90	39	90		360	11
12	Lights	3/10/2005		10,561	271	39	271		1,084	12
13	Dish Machine	6/5/2005		1,100	28	39	28		112	13
14	Improvements - Paint & Painting Supplies	10/1/2006		600	15	39	15		60	14
15	2nd Floor Remodeling - Cove Base for Rooms	11/1/2006		1,408	36	39	36		144	15
16	2nd Floor Remodeling - Wall Protection & Corner Guards	11/1/2006		2,372	61	39	61		244	16
17	2nd Floor Remodeling - Floor & Tile	11/1/2006		5,418	139	39	139		556	17
18	2nd Floor Remodeling - Paint & Painting Supplies	11/1/2006		14,919	383	39	383		1,532	18
19	2nd Floor Remodeling - Cove Base, Vertical Dividers, Wood Drift	11/1/2006		2,275	58	39	58		232	19
20	Fast Signs	1/9/2007		3,352	86	39	86		258	20
21	Cubicle Curtains	1/9/2007		1,117	29	39	29		86	21
22	Door Kickplates	1/9/2007		576	15	39	15		44	22
23	Draperies, Light Fixtures, Cascades	1/23/2007		28,189	723	39	723		2,168	23
24	Windows	1/23/2007		884	23	39	23		68	24
25	Painting & Supplies	2/1/2007		1,500	38	39	38		112	25
26	Water Pump & Boiler Tank	2/26/2007		8,875	228	39	228		664	26
27	Paint & Supplies	3/1/2007		2,657	68	39	68		193	27
28	Paint & Supplies	4/1/2007		5,520	142	39	142		389	28
29	Thermal Assembly	4/11/2007		2,179	56	39	56		154	29
30	Wall Paper, Wall Protection	5/1/2007		7,306	187	39	187		500	30
31	Paint & Supplies	5/1/2007		4,746	122	39	122		324	31
32	Heating & Cooling Pump	5/7/2007		4,214	108	39	108		288	32
33	Faucet	5/16/2007		1,425	37	39	37		97	33
34	Pump Motor	5/24/2007		910	23	39	23		62	34
35	Paint & Supplies	6/1/2007		8,833	226	39	226		585	35
36	Air Handler	6/4/2007		6,160	158	39	158		408	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 &amp; ID Number BELHAVEN NURSING &amp; REHABILITATION CENTER

# 0048215

Report Period Beginning:

1/1/09

Ending:

12/31/09

## 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	\$	\$ 527	37
38	Paint & Supplies	7/1/2007	4,744	122	39	122		304	38
39	Paint & Supplies	8/1/2007	5,247	135	39	135		325	39
40	Electric Work	8/2/2007	5,438	139	39	139		337	40
41	A/C	8/8/2007	2,534	65	39	65		157	41
42	Paint & Supplies	9/1/2007	4,393	113	39	113		263	42
43	Paint & Supplies	10/1/2007	6,499	167	39	167		375	43
44	Lights, Wall Protection, Draperies	10/9/2007	29,587	759	39	759		1,707	44
45	Shower Valve	11/1/2007	3,650	94	39	94		203	45
46	Paint & Supplies	11/1/2007	3,076	79	39	79		171	46
47	Electric Work	11/9/2007	10,269	263	39	263		570	47
48	Wall Covering	11/28/2007	3,161	81	39	81		176	48
49	Hydraulic Valve	11/28/2007	4,207	108	39	108		234	49
50	Paint & Supplies	12/1/2007	2,065	53	39	53		115	50
51	Kickplates/Wallcoverings	1/11/2008	3,130	80	39	80		161	51
52	Kickplates/Wallcoverings	4/24/2008	4,179	107	39	107		188	52
53	Wallpaper	1/11/2008	1,537	39	39	39		79	53
54	Sheeting	11/21/2008	1,111	28	39	28		33	54
55	Plumbing	6/10/2008	2,410	62	39	62		98	55
56	Water Heater parts replacement	5/13/2008	1,231	32	39	32		53	56
57	A/C Maintenance	5/15/2005	231	6	39	6		10	57
58	Valve Replacement	5/13/2008	3,650	94	39	94		156	58
59	A/C	5/22/2008	2,198	56	39	56		94	59
60	Air Vent	6/5/2008	813	21	39	21		33	60
61	Cooling Tower	6/20/2008	4,093	105	39	105		166	61
62	Freezer parts replacement	9/23/2008	1,208	31	39	31		41	62
63	Water Heater parts replacement	12/5/2008	1,516	39	39	39		42	63
64	Water Heater parts replacement	12/24/2008	969	25	39	25		27	64
65	Electrical	10/22/2008	655	17	39	17		21	65
66	Dining Room	1/15/2008	3,600	92	39	92		185	66
67	Paint/Remodel	2/5/2008	2,300	59	39	59		113	67
68	2nd Floor Paint/Remodel	4/4/2008	3,000	77	39	77		135	68
69	3rd Floor Paint/Remodel	5/16/2008	3,500	90	39	90		150	69
70	TOTAL (lines 4 thru 69)		\$ 5,803,623	\$ 148,811		\$ 148,811	\$	\$ 515,550	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number BELHAVEN NURSING &amp; REHABILITATION CENTER

# 0048215

Report Period Beginning:

1/1/09

Ending:

12/31/09

## 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	<b>Totals from Page 12A, Carried Forward</b>		\$ 5,803,623	\$ 148,811		\$ 148,811	\$	\$ 515,550	1
2	Paint/Remodel	5/22/2008	1,500	38	39	38		64	2
3	Concrete Work	6/6/2008	300	8	39	8		12	3
4	Remodel - Cabinets/Light Fixtures	9/12/2008	600	15	39	15		21	4
5	Remodel - Cabinets/Light Fixtures	9/12/2008	1,400	36	39	36		48	5
6	Remodel Supplies	10/14/2008	600	15	39	15		19	6
7	Remodel Supplies	1/15/2008	252	6	39	6		13	7
8	Remodel Supplies	2/5/2008	269	7	39	7		13	8
9	Remodel Supplies	4/14/2008	406	10	39	10		18	9
10	Remodel Supplies	4/21/2008	663	17	39	17		30	10
11	Remodel Supplies	4/23/2008	489	13	39	13		22	11
12	Remodel Supplies	5/16/2008	326	8	39	8		14	12
13	Remodel Supplies	5/22/2008	465	12	39	12		20	13
14	Remodel Supplies	9/11/2008	1,106	28	39	28		38	14
15	Remodel Supplies	9/2/2008	1,470	38	39	38		50	15
16	Remodel Supplies	9/12/2008	606	16	39	16		21	16
17	Elevator	4/10/2008	3,006	77	39	77		135	17
18	Elevator	7/21/2008	5,538	142	39	142		213	18
19	Elevator	12/26/2008	4,407	113	39	113		122	19
20	Sprinkler Repairs	7/31/2008	537	14	39	14		21	20
21	Sprinkler Repairs	8/28/2008	653	17	39	17		24	21
22	Sprinkler Repairs	8/29/2008	1,510	39	39	39		55	22
23	Sprinkler Repairs	8/31/2008	1,980	51	39	51		72	23
24	Sprinkler Repairs	8/31/2008	1,156	30	39	30		42	24
25	Doors	11/18/2008	350	9	39	9		10	25
26	Doors	11/20/2008	447	11	39	11		13	26
27	Paint/Remodel	10/6/2009	659	17	39	4	(13)	4	27
28	Floor Tile	8/19/2009	23,845	611	39	255	(357)	255	28
29	Refrigeration Repairs	1/1/2009	1,079	28	39	28	0	28	29
30	Install Pull Chain Damper	3/17/2009	650	17	39	14	(3)	14	30
31	Remodel Shower Room	7/8/2009	3,000	77	39	38	(38)	38	31
32	Remodel Shower Room	9/28/2009	3,000	77	39	26	(51)	26	32
33	Remodel Shower Room	11/18/2009	3,000	77	39	13	(64)	13	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 5,868,891	\$ 150,485		\$ 149,959	\$ (526)	\$ 517,037	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	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	<b>Totals from Page 12B, Carried Forward</b>		\$ 5,868,891	\$ 150,485		\$ 149,959	\$ (526)	\$ 517,037	1
2	Remodel Shower Room	12/30/2009	3,000	77	39	6	(71)	6	2
3	Remodel and Install Doors	10/20/2009	14,489	372	39	93	(279)	93	3
4	Remodel Supplies	12/17/2009	779	20	39	2	(18)	2	4
5	Remodel Supplies	12/31/2009	168	4	39	0	(4)	0	5
6	Sprinkler Repairs	8/31/2009	4,370	112	39	47	(65)	47	6
7	New Doors	4/16/2009	910	23	39	17	(6)	17	7
8	New Doors	6/3/2009	1,134	29	39	17	(12)	17	8
9	Painting and Construction	4/3/2009	9,625	247	39	185	(62)	185	9
10	New Faucets and Drains	10/7/2009	2,235	57	39	14	(43)	14	10
11	New Faucets and Drains	12/28/2009	1,290	33	39	3	(30)	3	11
12	New Faucets and Drains	12/21/2009	1,725	44	39	4	(41)	4	12
13	New Faucets and Drains	12/21/2009	1,725	44	39	4	(41)	4	13
14	New Roofing	9/14/2009	68,755	1,763	39	588	(1,175)	588	14
15	New Roofing	10/16/2009	1,950	50	39	13	(38)	13	15
16	Fix Airconditioning	9/17/2009	1,050	27	39	9	(18)	9	16
17	Painting and Construction	6/19/2009	785	20	39	12	(8)	12	17
18	Painting and Construction	5/21/2009	1,700	44	39	29	(15)	29	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 5,984,580	\$ 153,451		\$ 151,001	\$ (2,450)	\$ 518,079	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	\$ 415,506	\$ 111,855	\$ 71,740	\$ (40,115)	5	\$ 217,249	71
72	Current Year Purchases	81,941	7,903	7,903		5	7,903	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 497,447	\$ 119,758	\$ 79,643	\$ (40,115)		\$ 225,151	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)	\$ 6,582,027	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 273,209	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 230,643	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (42,565)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 743,230	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

**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

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

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.	<u>/2010</u>	\$ _____
13.	<u>/2011</u>	\$ _____
14.	<u>/2012</u>	\$ _____

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
  - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- 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	\$		\$ 264,061	\$		\$ 264,061	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs			102,294			102,294	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs			244,891			244,891	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 prescrpts				210,142		210,142	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <b>Radiology &amp; Lab</b>	39-2					14,037		14,037	13
14	<b>TOTAL</b>			\$		\$ 611,246	\$ 224,179		\$ 835,425	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

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (58,043)	\$ 843,572	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	4,648,731	6,022,332	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	290,678	290,677	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 4,881,366	\$ 7,156,581	10
	<b>B. Long-Term Assets</b>			
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	484,578	484,578	15
16	Equipment, at Historical Cost	347,447	497,447	16
17	Accumulated Depreciation (book methods)	(344,574)	(913,166)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		4,605,292	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(1,074,567)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 487,451	\$ 9,199,584	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 5,368,817	\$ 16,356,165	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 1,107,838	\$ 1,107,837	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	532,819	532,819	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		420,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Settlement Reserve</u>	375,000	375,000	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,015,657	\$ 2,435,656	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	950,000	950,000	39
40	Mortgage Payable		10,516,046	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 950,000	\$ 11,466,046	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,965,657	\$ 13,901,702	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 2,403,160	\$ 2,454,463	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 5,368,817	\$ 16,356,165	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b>	
		<b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,416,628</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>1,416,628</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>2,384,169</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(1,397,637)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>986,532</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>2,403,160</b>	<b>24</b> *

\* 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	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 12,540,461	1
2	Discounts and Allowances for all Levels	(598,860)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 11,941,601	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,063,095	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,063,095	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	177,392	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	18,823	19
20	Radiology and X-Ray	2,974	20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 199,189	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	1,002	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 1,002	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>VENDING INCOME</b>	2,066	28
28a	<b>MISCELLANEOUS REVENUE</b>	34,194	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 36,260	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 13,241,147	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,815,018	31
32	Health Care	5,119,545	32
33	General Administration	1,712,255	33
	<b>B. Capital Expense</b>		
34	Ownership	1,864,983	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	224,179	35
36	Provider Participation Fee	120,998	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 10,856,978	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	2,384,169	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 2,384,169	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:

1/1/09

Ending:

12/31/09

**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	2,066	2,283	\$ 88,448	\$ 38.74	1
2	Assistant Director of Nursing					2
3	Registered Nurses	22,422	24,573	761,272	30.98	3
4	Licensed Practical Nurses	54,461	59,262	1,428,085	24.10	4
5	CNAs & Orderlies	133,479	145,933	1,408,342	9.65	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	14,206	15,388	144,300	9.38	9
10	Activity Assistants					10
11	Social Service Workers	5,594	6,232	100,559	16.14	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	27,807	31,024	354,316	11.42	15
16	Dishwashers					16
17	Maintenance Workers	3,674	4,070	64,250	15.79	17
18	Housekeepers	24,255	27,625	284,028	10.28	18
19	Laundry	14,240	16,406	173,460	10.57	19
20	Administrator	2,459	2,591	91,716	35.40	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,814	8,595	132,165	15.38	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)	312,477	343,982	\$ 5,030,941 *	\$ 14.63	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	302	\$ 10,567	10-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	474	23,708	10-3	38
39	Pharmacist Consultant	50	2,500	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	144	5,027	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	970	\$ 41,802		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-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	5-13 Amount of Expense Amortized Per Year								
					6 FY2006	7 FY2007	8 FY2008	9 FY2009	10 FY2010	11 FY2011	12 FY2012	13 FY2013	14 FY2014
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

