

Facility Name & ID Number Maryhaven Nursing & Rehabilitation

0044768 Report Period Beginning: 07/01/09 Ending: 06/30/10

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 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	49,275	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	49,275	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	Private Pay	4 Other	Total	
8	SNF	22,636	12,487	7,360	42,483	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,636	12,487	7,360	42,483	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.22%

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 03/01/00

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 _____

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: 06/30/10 Fiscal Year: 06/30/10

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

Facility Name & ID Number

Maryhaven Nursing & Rehabilitation

0044768

Report Period Beginning:

07/01/09

Ending:

06/30/10

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	408,021	47,408	10,566	465,995		465,995		465,995		1
2	Food Purchase		288,761		288,761		288,761	(30,374)	258,387		2
3	Housekeeping	174,770	49		174,819		174,819		174,819		3
4	Laundry	113,557	62,874	476	176,907		176,907	(24,222)	152,685		4
5	Heat and Other Utilities			197,855	197,855		197,855		197,855		5
6	Maintenance	84,654	16,910	150,299	251,863		251,863		251,863		6
7	Other (specify):*										7
8	TOTAL General Services	781,002	416,002	359,196	1,556,200		1,556,200	(54,596)	1,501,604		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	2,618,234	73,680	22,556	2,714,470		2,714,470		2,714,470		10
10a	Therapy	289,787	1,879	11,269	302,935		302,935		302,935		10a
11	Activities	159,175	7,660	6,600	173,435		173,435		173,435		11
12	Social Services	73,855			73,855		73,855		73,855		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,141,051	83,219	58,425	3,282,695		3,282,695		3,282,695		16
	C. General Administration										
17	Administrative	100,030		1,001,941	1,101,971		1,101,971	(1,001,941)	100,030		17
18	Directors Fees										18
19	Professional Services										19
20	Dues, Fees, Subscriptions & Promotions			8,761	8,761		8,761		8,761		20
21	Clerical & General Office Expenses	340,590	33,422	32,504	406,516		406,516	596,116	1,002,632		21
22	Employee Benefits & Payroll Taxes			1,683,516	1,683,516		1,683,516	68,277	1,751,793		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,022	5,022		5,022		5,022		24
25	Other Admin. Staff Transportation			(12,966)	(12,966)		(12,966)		(12,966)		25
26	Insurance-Prop.Liab.Malpractice			(15,881)	(15,881)		(15,881)		(15,881)		26
27	Other (specify):*										27
28	TOTAL General Administration	440,620	33,422	2,702,897	3,176,939		3,176,939	(337,548)	2,839,391		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,362,673	532,643	3,120,518	8,015,834		8,015,834	(392,144)	7,623,690		29

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

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

Facility Name & ID Number

Maryhaven Nursing & Rehabilitation

#0044768

Report Period Beginning:

07/01/09

Ending:

06/30/10

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			459,637	459,637		459,637	67,320	526,957			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			114,637	114,637		114,637	(97,664)	16,973			32
33	Real Estate Taxes			98,837	98,837		98,837		98,837			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			19,614	19,614		19,614		19,614			35
36	Other (specify):*											36
37	TOTAL Ownership			692,725	692,725		692,725	(30,344)	662,381			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		710,737		710,737		710,737		710,737			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			73,913	73,913		73,913		73,913			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		710,737	73,913	784,650		784,650		784,650			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,362,673	1,243,380	3,887,156	9,493,209		9,493,209	(422,488)	9,070,721			45

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

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	(30,374)	2		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	(24,222)	4		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	(20,435)	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 See Page 5a	(20,124)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (95,155)		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (95,155)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	52

Maryhaven Nursing & Rehabilitation

ID# 0044768

Report Period Beginning: 07/01/09

Ending: 06/30/10

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1		\$		1
2	Miscellaneous Revenue Offset	(20,124)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(20,124)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Maryhaven Nursing & Rehabilitation# 0044768

Report Period Beginning:

07/01/09

Ending:

06/30/10

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(30,374)	0	0	0	0	0	0	0	0	0	0	(30,374)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(24,222)	0	0	0	0	0	0	0	0	0	0	(24,222)	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	(54,596)	0	0	0	0	0	0	0	0	0	0	(54,596)	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	(1,001,941)	0	0	0	0	0	0	0	0	0	(1,001,941)	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	(40,559)	636,675	0	0	0	0	0	0	0	0	0	596,116	21
22	Employee Benefits & Payroll Taxes	0	68,277	0	0	0	0	0	0	0	0	0	68,277	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	(40,559)	(296,989)	0	(337,548)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(95,155)	(296,989)	0	(392,144)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Maryhaven Nursing & Rehabilitation# 0044768

Report Period Beginning:

07/01/09

Ending:

06/30/10

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	67,320	0	0	0	0	0	0	0	0	0	67,320	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	(97,664)	0	0	0	0	0	0	0	0	0	(97,664)	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	0	(30,344)	0	(30,344)	37								
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(95,155)	(327,333)	0	0	0	0	0	0	0	0	0	(422,488)	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:	
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	<u>21 Clerical & data processing</u>	\$	<u>Resurrection Health Care</u>	<u>100.00%</u>	\$ <u>636,675</u>	\$ <u>636,675</u>	1
2	V	<u>22 Employee benefits</u>		<u>Resurrection Health Care</u>	<u>100.00%</u>	<u>68,277</u>	<u>68,277</u>	2
3	V	<u>30 Depreciation</u>		<u>Resurrection Health Care</u>	<u>100.00%</u>	<u>67,320</u>	<u>67,320</u>	3
4	V	<u>32 Interest Expense</u>	<u>114,637</u>	<u>Resurrection Health Care</u>	<u>100.00%</u>	<u>16,973</u>	<u>(97,664)</u>	4
5	V							5
6	V	<u>17 Intercompany expense</u>	<u>1,001,941</u>	<u>Resurrection Health Care</u>	<u>100.00%</u>		<u>(1,001,941)</u>	6
7	V	<u>39 Intercompany pharmacy</u>	<u>710,737</u>	<u>Resurrection Health Care</u>	<u>100.00%</u>	<u>710,737</u>		7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ <u>1,827,315</u>			\$ <u>1,499,982</u>	\$ * <u>(327,333)</u>	14

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

Resurrection Health Care
Schedule for Form 990
Page 5, Part VI, Line 80b
Related Organizations
Twelve Months Ending June 30, 2010

Related Organizations	Fed Tax ID No	Tax Status
Family Medical Network	36-3961066	Non-Exempt
Holy Family Health Care Systems, Inc.	36-3495969	Exempt
Holy Family Nursing & Rehab Center	36-3121158	Exempt
Holy Family Medical Center	36-2439318	Exempt
Key Opportunities Inc.	36-3499869	Non-Exempt
L. Gilbraith Insurance SPC Ltd.		Non-Exempt
Mount Loretto Nursing Home	14-1363014	Exempt
Our Lady of Resurrection Medical Center	36-2644178	Exempt
Proviso Family Services, Inc. - DBA Resurrection Behavioral Health	36-2709982	Exempt
Resurrection Development Foundation	36-3330929	Exempt
Resurrection Health Care	36-2235165	Exempt
Resurrection Health Care Preferred, Inc.	36-3974620	Non-Exempt
Resurrection Home Health Foundation	36-3466794	Exempt
Resurrection Home Health Services	36-2893936	Exempt
Resurrection Medical Center	36-3330926	Exempt
Resurrection Rest Home	14-1348691	Exempt
Resurrection Senior Services	23-7061646	Exempt
Resurrection Services	36-3330928	Exempt
Saint Francis Hospital of Evanston	36-2167800	Exempt
Saint Joseph Hospital	36-3200170	Exempt
Saints Mary and Elizabeth Medical Center	36-2171079	Exempt
Saint Mary of Nazareth PHO	36-4006358	Non-Exempt
Stamana, Inc.	36-3314912	Non-Exempt
Westlake Community Hospital	36-1649520	Exempt
West Suburban Health Providers	36-3980942	Non-Exempt
West Suburban Health Services	36-4286236	Exempt
West Suburban Medical Center	36-2182170	Exempt

RESURRECTION SENIOR SERVICES
BOARD OF DIRECTORS
OCTOBER 1, 2009

Name	Office
Mr. Joseph F. Toomey	President and CEO Resurrection Health Care 7435 W. Talcott Avenue, Suite 520 Chicago, IL 60631 Phone: 773-792-5555; Fax 773-990-8601 Email: DEJesus-ortiz@reshealthcare.org
Sister Donna Marie Wolowicki, C.R.	Executive Vice President/CEO Resurrection Health Care 7435 W. Talcott Avenue, Suite 520 Chicago, IL 60631 Phone: 773-792-5153; Fax - 773-990-7626 Email: srdmarie@reshealthcare.org
Mr. John R. Walton	Group Executive Vice President/CEO Senior Services Holy Family Medical Center 100 North River Road Des Plaines, IL 60016 Phone: 847-813-3160 ; Fax: 847-813-3876 Email: Jwalton@reshealthcare.org
Michael Rosenberg, M.D.	Director, Emergency Medicine Resurrection Medical Center 7435 W. Talcott Avenue, Suite 520 Chicago, IL 60631 Phone: 773-792-5219; Fax 773-594-7980 Email: Morsenberg@reshealthcare.org Director, Emergency Medicine Our Lady of the Resurrection Medical Center 5645 W. Addison Chicago, IL 60634 Phone: 773-794-7602; Fax 773-794-7664 Email: Morsenberg@reshealthcare.org
Sister Elizabeth Trembczynski, CSFN	Administrator Case San Carlo Retirement Community 420 N. Wolf Road Northlake, IL 60164 Phone: 708-561-4300; Fax - 708-562-5677 Email: Etrem@reshealthcare.org

RESURRECTION SENIOR SERVICES
OFFICERS
OCTOBER 1, 2009

Title	Name
President	Mr. Joseph F. Toomey
Group Vice President and EVP/CEO	Mr. John R. Walton
Secretary	Mr. Jeannie C. Frey
Treasurer	
Assistance Secretary	Mr. John R. Walton

Facility Name & ID Number Maryhaven Nursing & Rehabilitation # 0044768 Report Period Beginning: 07/01/09 Ending: 06/30/10

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	See attached pg. 7A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number Maryhaven Nursing & Rehabilitation

0044768

Report Period Beginning:

07/01/09

Ending: 06/30/10

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

Resurrection Health Care/Medical Center

Street Address

7435 West Talcott

City / State / Zip Code

Chicago, IL 60631

Phone Number

(773) 774-8000

Fax Number

(773) 594-7488

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.

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	Clerical & data processing				\$	\$		\$ 636,675	1
2	Employee benefits							68,277	2
3	Depreciation							67,320	3
4	Interest Expense							16,973	4
5									5
6	Intercompany Pharmacy							710,737	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				\$	\$		\$ 1,499,982	25

Facility Name & ID Number

Maryhaven Nursing & Rehabilitation

0044768

Report Period Beginning:

07/01/09

Ending:

06/30/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		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									1										
2										2										
3										3										
4										4										
5										5										
Working Capital																				
6	N/A									6										
7										7										
8										8										
9	TOTAL Facility Related					\$	\$		\$	9										
B. Non-Facility Related*																				
10	N/A									10										
11							Allocated from Home Office		16,973	11										
12										12										
13										13										
14	TOTAL Non-Facility Related					\$	\$		\$ 16,973	14										
15	TOTALS (line 9+line14)					\$	\$		\$ 16,973	15										

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

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

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

2009 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 2009 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2009.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>Facility is a not-for-profit and does not pay real estate taxes.</u>		\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
TOTALS			\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

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 2009 report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2005	_____	8
	2006	_____	9
	2007	_____	10
	2008	_____	11
	2009	_____	12
Facility is a not-for-profit and does not pay real estate taxes.			
	FOR BHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2009 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

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

Facility Name & ID Number Maryhaven Nursing & Rehabilitation

0044768

Report Period Beginning:

07/01/09

Ending:

06/30/10

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).

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>83,762</u>	<u>2000</u>	<u>\$ 3,000,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	83,762		\$ 3,000,000	3

Facility Name & ID Number Maryhaven Nursing & Rehabilitation

0044768

Report Period Beginning:

07/01/09

Ending:

06/30/10

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		\$ 1,847,321	4
5			2006		2,137	142	15	142		355	5
6											6
7											7
8											8
	Improvement Type**										
9	Facility		2000		7,995		10				9
10	Plumbing		2001		7,539		10				10
11	Architect Fees		2001		3,299		20				11
12	Architect Fees		2001		3,097		20				12
13	Landscape Architect		2001		1,478		20				13
14	Topographic mapping		2001		9,386		20				14
15	Cooler Repair		2000		766		20				15
16	Hot water softener		2001		1,150		20				16
17	Freezer repair		2001		974		20				17
18	HVAC		2001		563		20				18
19	HVAC		2001		872		20				19
20	Fire panel		2001		775		20				20
21	Mechanical repairs		2001		3,565		20				21
22	Cooler repair		2001		4,121		20				22
23	Water chiller		2000		49,020		15				23
24	Professional services, renovation		2001		20,422		10				24
25	Landscape Architect		2001		11,815		20				25
26	Floor painting		2001		499		20				26
27	Stainless steel kick plate		2001		893		20				27
28	Dry wall guard		2001		775		20				28
29	Windows		2001		994		20				29
30	Heating & cooling		2002		623		20				30
31	Swing door gaskets		2002		599		20				31
32	Remove work duct		2002		971		20				32
33	Air coil		2002		951		20				33
34	Reconnect work duct		2002		643		20				34
35	Water main repair		2001		1,880		20				35
36											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

Facility Name & ID Number Maryhaven Nursing & Rehabilitation

0044768

Report Period Beginning:

07/01/09

Ending:

06/30/10

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		882	58
59	Prof. Engin. Civil Services	2003	994	99	10	99		497	59
60	Repair Check Valve in Circuit #2	2003	5,014	501	10	501		2,507	60
61	Private Office LLB - 9	2003	1,428	95	15	95		477	61
62	Phase II Site Drain - Pr.S. 9/27/03 - 10/31/03	2003	362	24	15	24		120	62
63	Install side steam filter system	2003	2,695	270	10	270		1,350	63
64	Install heat-timer control system	2003	6,980	698	10	698		3,490	64
65	Install 4 plastic laminate gates at nurses stations	2004	1,760	108	15	108		560	65
66	Installation of 67 fire dampers	2004	20,560	2,056	10	2,056		10,280	66
67	Installation of new phone & paging system	2004	10,592	1,059	10	1,059		5,297	67
68	Nortel Norstar voicemail call pilot 150 new	2004	3,000	600	5	600		3,000	68
69	Installation of new LCN 7780 series control	2004	2,383	238	10	238		1,190	69
70	TOTAL (lines 4 thru 69)		\$ 8,043,902	\$ 203,831		\$ 203,831	\$	\$ 1,877,326	70

**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:

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Ending:

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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	\$	\$ 1,877,326	1
2	Labor & material to install 2 new hot water boilers	2004	46,411	4,641	10	4,641		25,526	2
3									3
4	Excavation & Placement of concrete sidewalk	2005	3,960	264	15	264		1,188	4
5	Seal coat & restripe, pothole patching, crackseal	2005	5,300	530	10	530		2,385	5
6									6
7									7
8	Boiler Maintenance	2005	1,930	97	20	97		459	8
9	Building and renovation project costs	2005	2,037	204	10	204		918	9
10	Vinyl Tile w/border	2005	19,137	1,914	10	1,914		8,613	10
11	Replace 6" copper tee w/ 6" elbow	2005	2,220	222	10	222		999	11
12	Replace valve, replace all 6" pipe w/ 3" pipe	2005	7,555	756	10	756		3,402	12
13	Install push button, access back to back keyspace	2005	2,769	396	7	396		1,782	13
14	Sprinklers to new drop ceiling	2005	950	95	5	95		855	14
15									15
16									16
17	Placement of sidewalks & concrete pad	2006	3,450	230	15	230		805	17
18	Placement of concrete pad at dryer vent	2006	1,500	100	15	100		350	18
19	Flooring	2006	8,136	814	10	814		2,849	19
20	Electrical installation & connection	2006	6,314	789	8	789		2,762	20
21	Installation of new duct work	2006	10,000	667	15	667		2,334	21
22	Base & wall mount cabinetry for PT room	2006	6,123	408	15	408		1,428	22
23	Fire Sprinkler/13 concealed heads from exist. 1/2"	2006	3,640	243	15	243		850	23
24	Pipe evaporative condensor w/Trane	2006	15,270	1,527	10	1,527		5,345	24
25	Landscaping Architecture	2006	3,500	438	8	438		1,439	25
26	Rewire emergency power circuit	2006	4,012	658	5	658		3,354	26
27	Repairs to walk in freezer, compressor & milk cooler	2006	1,803	120	15	120		908	27
28									28
29	Excavation & Removal of Grass & Dirt	2006	6,550	935	7	935		2,338	29
30	Install Electrically connect illum.in.sign	2006	6,347	908	7	908		2,269	30
31	Prep and pain front entrance	2006	4,885	698	7	698		1,745	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,217,701	\$ 221,485		\$ 221,485	\$	\$ 1,952,229	34

**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	\$ 221,485		\$ 221,485	\$	\$ 1,952,229	1
2	Hallway lights lamps	2006	19,200	2,400	8	2,400		8,400	2
3	Run Electrical Power for new sign	2006	4,294	537	8	537		1,879	3
4	Installation of Brick and concrete sign pillar	2007	2,310	289	8	289		1,011	4
5									5
6	Sump Drains & Installation	2008	73,448	3,672	20	3,672		7,344	6
7									7
8	Lighting retrofit	2010	16,263	814	10	814		814	8
9	Code alert wander system	2010	7,721	551	7	551		551	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	Home office allocation					67,320	67,320		31
32	Financial Statement Depreciation			123,920		123,920		1,638,246	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,340,937	\$ 353,668		\$ 420,988	\$ 67,320	\$ 3,610,474	34

**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:

07/01/09

Ending:

06/30/10

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,473,405	\$ 105,969	\$ 105,969	\$	5-20	\$ 1,063,711	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,473,405	\$ 105,969	\$ 105,969	\$		\$ 1,063,711	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	\$	\$	\$		\$ 5,030	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)	\$ 12,819,372	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 459,637	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 526,957	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 67,320	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,679,215	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.

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:	<u>N/A</u>			\$			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: \$ 19,614

Description: Copiers& fax machcines

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. /2011 \$ _____

13. /2012 \$ _____

14. /2013 \$ _____

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10A(1,2,3)	2088	hrs	\$ 92,271	43	\$ 2,625	\$	2,131	\$ 94,896	1
2	Licensed Speech and Language Development Therapist	10A(1,2,3)	454	hrs	17,412	31	2,039		485	19,451	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10A(1,2,3)	5575	hrs	183,396	115	6,534		5,690	189,930	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				710,737		710,737	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				\$ 293,079	189	\$ 11,198	\$ 710,737	8,306	\$ 1,015,014	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/10

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 134,217	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>859,378</u>)	624,582		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	81,963		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 840,762	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	2,935,798		13
14	Buildings, at Historical Cost	7,839,180		14
15	Leasehold Improvements, at Historical Cost	83,952		15
16	Equipment, at Historical Cost	1,965,322		16
17	Accumulated Depreciation (book methods)	(4,679,215)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 8,145,037	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,985,799	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,614,936	\$	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				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,614,936	\$	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)	\$ 1,614,936	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 7,370,863	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,985,799	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 7,955,585	1
2	Restatements (describe):		2
3	Prior Period Adjustment	(8,314)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 7,947,271	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(576,408)	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)	\$ (576,408)	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)	\$ 7,370,863	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Maryhaven Nursing & Rehabilitation# 0044768Report Period Beginning: 07/01/09Ending: 06/30/10

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 9,562,847	1
2	Discounts and Allowances for all Levels	(2,376,084)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,186,763	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,910,918	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,910,918	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	30,374	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	17,178	21
22	Laundry	24,222	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 71,774	23
D. Non-Operating Revenue			
24	Contributions	451	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 451	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transfers from Temporary Restricted funds</u>	185	28
28a	<u>Miscellaneous Income</u>	2,946	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,131	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,173,037	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,556,200	31
32	Health Care	3,282,695	32
33	General Administration	3,196,553	33
B. Capital Expense			
34	Ownership	673,111	34
C. Ancillary Expense			
35	Special Cost Centers	710,737	35
36	Provider Participation Fee	73,913	36
D. Other Expenses (specify):			
37			37
38	<u>Provision for Uncollectable</u>	256,236	38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,749,445	40
41	Income before Income Taxes (line 30 minus line 40)**	(576,408)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (576,408)	43

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

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

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

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

Facility Name & ID Number Maryhaven Nursing & Rehabilitation

0044768

Report Period Beginning: 07/01/09

Ending:

06/30/10

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	1,872	2,080	\$ 100,213	\$ 48.18	1
2	Assistant Director of Nursing	1,914	2,080	81,780	39.32	2
3	Registered Nurses	28,269	31,095	1,113,442	35.81	3
4	Licensed Practical Nurses	5,783	6,747	178,649	26.48	4
5	CNAs & Orderlies	68,458	75,599	1,090,849	14.43	5
6	CNA Trainees					6
7	Licensed Therapist	7,311	8,117	293,079	36.11	7
8	Rehab/Therapy Aides	3,830	4,197	53,256	12.69	8
9	Activity Director	1,528	1,792	42,112	23.50	9
10	Activity Assistants	4,766	5,813	70,789	12.18	10
11	Social Service Workers	2,809	3,121	73,610	23.59	11
12	Dietician	909	1,076	21,424	19.91	12
13	Food Service Supervisor	3,797	4,206	97,512	23.18	13
14	Head Cook	7,085	7,828	109,291	13.96	14
15	Cook Helpers/Assistants	15,145	16,945	179,443	10.59	15
16	Dishwashers					16
17	Maintenance Workers	3,607	3,913	84,987	21.72	17
18	Housekeepers	14,786	16,019	168,354	10.51	18
19	Laundry	8,426	9,579	117,571	12.27	19
20	Administrator	1,852	2,080	100,030	48.09	20
21	Assistant Administrator					21
22	Other Administrative	10,661	11,726	236,843	20.20	22
23	Office Manager					23
24	Clerical					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	2,605	2,775	102,942	37.10	32
33	Other(specify) <u>Religious Wages</u>	1,597	1,757	46,497	26.46	33
34	TOTAL (lines 1 - 33)	197,010	218,545	\$ 4,362,673 *	\$ 19.96	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				36
37	Medical Records Consultant	Monthly	18,000	9(3)	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)		\$ 18,000		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

Maryhaven Nursing and Rehab Center

Provider # 0044768

7/1/2009 - 6/30/2010

Schedule 21A

XIX - Support Schedules Item G. Seminar Expense

Sum of Amount Name	Total
Northern	2,560
Illinois	599
HCPRO	385
Barkon, IN	153
Premier	125
Lawhorn, S	630
SZUMSKI,S	271
Mayfield	100
Social Worker	199
Grand Total	<u>5,022</u>

Facility Name & ID Number Maryhaven Nursing & Rehabilitation# 0044768Report Period Beginning: 07/01/09Ending: 06/30/10**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount. LSN 1939, ICLTC 2087
- (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. \$ 13,223 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.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 73,913
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 30,374
- (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? 100
d. Have vehicle usage logs been maintained? Adequate records are 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? _____
Firm Name: KPMG LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.