FOR BHF USE

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0048215

Facility Name: BELHAVEN NURSING & REHABILITATION CENTER

Address: 11401 SOUTH OAKLEY AVENUE (Number) CHICAGO (City) 60643 (Zip Code)

County: COOK

Telephone Number: (773) 233-6311 **Fax #** (733) 233-9304

HFS ID Number:

Date of Initial License for Current Owners: 7/1/06

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: DANIEL S. GAAFAR **Telephone Number:** (317) 237-5500
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/10 to 12/31/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) MOISHE GUBIN
(Title) MANAGER

Paid Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT ATTACHED (Date)
(Print Name and Title) DANIEL S. GAAFAR, PARTNER
(Firm Name & Address) BRADLEY & ASSOCIATES, INC., 201 S. CAPITOL AVE, SET 910, INDIANAPOLIS, IN 46225
(Telephone) (317) 237-5500 Fax # (317) 237-5503

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BELHAVEN NURSING & REHABILITATION CENTER # 0048215 Report Period Beginning: 1/1/10 Ending: 12/31/10

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	58,745	3,334	9,305	71,384	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	58,745	3,334	9,305	71,384	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.49%

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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

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 [X] Date 7/11/06 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 221 and days of care provided 7,518

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/10 Fiscal Year: 12/31/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BELHAVEN NURSING & REHABILITATI(# 0048215 Report Period Beginning: 1/1/10 Ending: 12/31/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	295,216	39,454	15,000	349,670		349,670	(869)	348,801			1
2	Food Purchase		330,668		330,668		330,668		330,668			2
3	Housekeeping	265,848	41,882		307,730		307,730		307,730			3
4	Laundry	170,428	30,087		200,515		200,515		200,515			4
5	Heat and Other Utilities			345,943	345,943		345,943		345,943			5
6	Maintenance	67,471	26,752	73,723	167,946		167,946	(789)	167,157			6
7	Other (specify):*											7
8	**TOTAL General Services**	798,963	468,843	434,666	1,702,472		1,702,472	(1,658)	1,700,814			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	3,781,282	588,421	27,661	4,397,364		4,397,364	21,174	4,418,538			10
10a	Therapy			621,910	621,910		621,910		621,910			10a
11	Activities	152,979	28,006		180,985		180,985		180,985			11
12	Social Services	65,866		2,682	68,548		68,548		68,548			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* **Pharmacy Consult**			23,920	23,920		23,920		23,920			15
16	**TOTAL Health Care and Programs**	4,000,127	616,427	688,173	5,304,727		5,304,727	21,174	5,325,901			16
	C. General Administration											
17	Administrative	116,803			116,803		116,803		116,803			17
18	Directors Fees											18
19	Professional Services			302,543	302,543		302,543	(280,658)	21,885			19
20	Dues, Fees, Subscriptions & Promotions			3,313	3,313		3,313	497	3,810			20
21	Clerical & General Office Expenses	173,766	77,819	19,156	270,741		270,741	41,474	312,215			21
22	Employee Benefits & Payroll Taxes			751,231	751,231		751,231	29,028	780,259			22
23	Inservice Training & Education											23
24	Travel and Seminar			12,664	12,664		12,664	437	13,101			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			297,048	297,048		297,048	65,170	362,218			26
27	Other (specify):*											27
28	**TOTAL General Administration**	290,569	77,819	1,385,955	1,754,343		1,754,343	(144,052)	1,610,291			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,089,659	1,163,089	2,508,794	8,761,542		8,761,542	(124,536)	8,637,006			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number BELHAVEN NURSING & REHABILITATION CENTER #0048215 Report Period Beginning: 1/1/10 Ending: 12/31/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			128,375	128,375		128,375	129,719	258,094			30
31	Amortization of Pre-Op. & Org.							307,019	307,019			31
32	Interest			97,964	97,964		97,964	572,268	670,232			32
33	Real Estate Taxes							362,230	362,230			33
34	Rent-Facility & Grounds			1,680,000	1,680,000		1,680,000	(1,679,185)	815			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			1,906,339	1,906,339		1,906,339	(307,949)	1,598,390			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		327,729		327,729		327,729		327,729			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	TOTAL Special Cost Centers		327,729	120,998	448,727		448,727		448,727			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,089,659	1,490,818	4,536,131	11,116,608		11,116,608	(432,485)	10,684,123			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

Facility Name & ID Number BELHAVEN NURSING & REHABILITATION CENTEI # 0048215 Report Period Beginning: 1/1/10 Ending: 12/31/10

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(32,736)	30		9
10	Interest and Other Investment Income	(54,974)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(76)	1		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(4,880)	21		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	(22,471)	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	(61,255)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (176,392)		$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 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)	(256,093)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$ (256,093)		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (432,485)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44						44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

BELHAVEN NURSING & REHABILITATION CENTER

ID# 0048215

Report Period Beginning: 1/1/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	VENDING INCOME	$ (861)	6	1
2	MEDICAL RECORDS INCOME	(550)	10	2
3	MISCELLANEOUS INCOME	(60,069)	21	3
4	INSURANCE INCOME	225	26	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**	(61,255)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BELHAVEN NURSING & REHABILITATION CENTER **#** 0048215 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

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	(76)	(793)	0	0	0	0	0	0	0	0	0	(869)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(861)	72	0	0	0	0	0	0	0	0	0	(789)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(937)	(721)	0	0	0	0	0	0	0	0	0	(1,658)	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	(550)	21,724	0	0	0	0	0	0	0	0	0	21,174	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**	(550)	21,724	0	0	0	0	0	0	0	0	0	21,174	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(280,658)	0	0	0	0	0	0	0	0	0	(280,658)	19
20	Fees, Subscriptions & Promotions	0	497	0	0	0	0	0	0	0	0	0	497	20
21	Clerical & General Office Expenses	(87,420)	128,894	0	0	0	0	0	0	0	0	0	41,474	21
22	Employee Benefits & Payroll Taxes	0	29,028	0	0	0	0	0	0	0	0	0	29,028	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	437	0	0	0	0	0	0	0	0	0	437	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	225	498	64,447	0	0	0	0	0	0	0	0	65,170	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(87,195)	(121,304)	64,447	0	0	0	0	0	0	0	0	(144,052)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(88,682)	(100,301)	64,447	0	0	0	0	0	0	0	0	(124,536)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BELHAVEN NURSING & REHABILITATION CENTER # 0048215 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(32,736)	0	162,455	0	0	0	0	0	0	0	0	129,719	30
31	Amortization of Pre-Op. & Org.	0	0	307,019	0	0	0	0	0	0	0	0	307,019	31
32	Interest	(54,974)	0	627,242	0	0	0	0	0	0	0	0	572,268	32
33	Real Estate Taxes	0	0	362,230	0	0	0	0	0	0	0	0	362,230	33
34	Rent-Facility & Grounds	0	815	(1,680,000)	0	0	0	0	0	0	0	0	(1,679,185)	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	(87,710)	815	(221,054)	0	0	0	0	0	0	0	0	(307,949)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(176,392)	(99,486)	(156,607)	0	0	0	0	0	0	0	0	(432,485)	45

Facility Name & ID Number BELHAVEN NURSING & REHABILITATION CENTER # 0048215 Report Period Beginning: 1/1/10 Ending: 12/31/10

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
MICHAEL BLISKO	35%			Infinity Healthcare	Hillside, IL	Management Co.
MOISHE GUBIN	35%					
A&F GENERAL PARTNERSHIP	30%					

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	DIETARY	$ 13,750	INFINITY HEALTHCARE MANAGEMENT		$ 12,957	$ (793)	1
2	V	10	NURSING	23,260	INFINITY HEALTHCARE MANAGEMENT		44,984	21,724	2
3	V	19	PROFESSIONAL SERVICES	293,450	INFINITY HEALTHCARE MANAGEMENT		532	(292,918)	3
4	V	21	OFFICE EXPENSE	7,244	INFINITY HEALTHCARE MANAGEMENT		136,055	128,811	4
5	V	22	EMPLOYEE EXPENSE	3,403	INFINITY HEALTHCARE MANAGEMENT		32,431	29,028	5
6	V	24	AUTO/TRAVEL EXPENSE	372	INFINITY HEALTHCARE MANAGEMENT		809	437	6
7	V	6	MAINTENANCE		INFINITY HEALTHCARE MANAGEMENT		72	72	7
8	V	20	CLASSIFIED ADS		INFINITY HEALTHCARE MANAGEMENT		247	247	8
9	V	26	INSURANCE		INFINITY HEALTHCARE MANAGEMENT		498	498	9
10	V	34	RENT		INFINITY HEALTHCARE MANAGEMENT		815	815	10
11	V	19	PROFESSIONAL SERVICES		BELHAVEN REALTY, LLC		12,260	12,260	11
12	V	20	FILING FEES		BELHAVEN REALTY, LLC		250	250	12
13	V	21	OFFICE EXPENSE		BELHAVEN REALTY, LLC		83	83	13
14	Total			$ 341,479			$ 241,993	$ * (99,486)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BELHAVEN NURSING & REHABILITATION CENTER # 0048215 Report Period Beginning: 1/1/10 Ending: 12/31/10

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	26	INSURANCE	$	BELHAVEN REALTY, LLC		$ 64,447	$ 64,447	15
16	V	30	DEPRECIATION		BELHAVEN REALTY, LLC		162,455	162,455	16
17	V	31	AMORTIZATION		BELHAVEN REALTY, LLC		307,019	307,019	17
18	V	32	INTEREST		BELHAVEN REALTY, LLC		627,242	627,242	18
19	V	33	REAL ESTATE TAXES		BELHAVEN REALTY, LLC		362,230	362,230	19
20	V	34	RENT	1,680,000	BELHAVEN REALTY, LLC			(1,680,000)	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			$ 1,680,000			$ 1,523,393	$ * (156,607)	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: 1/1/10 Ending: 12/31/10

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									$		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BELHAVEN NURSING & REHABILITATION CENTEF # 0048215 Report Period Beginning: 1/1/10 Ending: 12/31/10

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 [X]

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BELHAVEN NURSING & REHABILITATI(# 0048215 Report Period Beginning: 1/1/10 Ending: 12/31/10

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	HUD		X	MORTGAGE	$105,131.00	10/24/08	$ 10,616,000	$ 10,417,761	10/24/2043	5.9900	$ 627,242	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MIDWEST BANK & TRUST CO.		X	WORKING CAPITAL	NONE	7/11/06	2,800,000	1,450,000	6/1/2010	8.2500	97,964	6
7												7
8												8
9	TOTAL Facility Related				$105,131.00		$ 13,416,000	$ 11,867,761			$ 725,206	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 13,416,000	$ 11,867,761			$ 725,206	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.)

Facility Name & ID Number BELHAVEN NURSING & REHABILITATION CENTER # 0048215 Report Period Beginning: 1/1/10 Ending: 12/31/10

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 363,886	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.)		$ 377,411	2
3. Under or (over) accrual (line 2 minus line 1).		$ 13,525	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 348,705	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.		$ 362,230	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	417,369	8
	2006	368,191	9
	2007	364,216	10
	2008	368,116	11
	2009	377,411	12

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.

SEE ACCOUNTANTS' COMPILATION REPORT

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BELHAVEN NURSING & REHABILITATION CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0048215

CONTACT PERSON REGARDING THIS REPORT DANIEL S. GAAFAR

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

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	25-19-110-040-0000	Nursing Home	$ 377,410.78	$ 377,410.78
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 377,410.78	$ 377,410.78

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation 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.

Facility Name & ID Number BELHAVEN NURSING & REHABILITATION CENTER # 0048215 Report Period Beginning: 1/1/10 Ending: 12/31/10

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 [X] (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? [X] (a) Own the Equipment [X] (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? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 4,605,292
2. Number of Years Over Which it is Being Amortized: 15
3. Current Period Amortization: 307,019
4. Dates Incurred: PRIOR TO 7/11/06

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

XI. OWNERSHIP COSTS:

A. Land.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BELHAVEN NURSING & REHABILITATION CENTER # 0048215 Report Period Beginning: 1/1/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	221		2006		$ 5,500,000	$ 141,026	39	$ 141,026	$	$ 634,617	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Dish Machine			12/8/2006	1,875	48	39	48		240	9
10	Wanderguard Security Camera			7/25/2006	37,000	949	39	949		4,745	10
11	Elevator Items			9/6/2006	3,495	90	39	90		450	11
12	Lights			10/9/2006	10,561	271	39	271		1,355	12
13	Dish Machine			11/14/2006	1,100	28	39	28		140	13
14	Improvements - Paint & Painting Supplies			10/1/2006	600	15	39	15		75	14
15	2nd Floor Remodeling - Cove Base for Rooms			11/1/2006	1,408	36	39	36		180	15
16	2nd Floor Remodeling - Wall Protection & Corner Guards			11/1/2006	2,372	61	39	61		305	16
17	2nd Floor Remodeling - Floor & Tile			11/1/2006	5,418	139	39	139		695	17
18	2nd Floor Remodeling - Paint & Painting Supplies			11/1/2006	14,919	383	39	383		1,915	18
19	2nd Floor Remodeling - Cove Base, Vertical Dividers, Wood Drift			11/1/2006	2,275	58	39	58		290	19
20	Fast Signs			1/9/2007	3,352	86	39	86		344	20
21	Cubicle Curtains			1/9/2007	1,117	29	39	29		115	21
22	Door Kickplates			1/9/2007	576	15	39	15		59	22
23	Draperies, Light Fixtures, Cascades			1/23/2007	28,189	723	39	723		2,891	23
24	Windows			1/23/2007	884	23	39	23		91	24
25	Painting & Supplies			2/1/2007	1,500	38	39	38		151	25
26	Water Pump & Boiler Tank			2/26/2007	8,875	228	39	228		891	26
27	Paint & Supplies			3/1/2007	2,657	68	39	68		261	27
28	Paint & Supplies			4/1/2007	5,520	142	39	142		531	28
29	Thermal Assembly			4/11/2007	2,179	56	39	56		210	29
30	Wall Paper, Wall Protection			5/1/2007	7,306	187	39	187		687	30
31	Paint & Supplies			5/1/2007	4,746	122	39	122		446	31
32	Heating & Cooling Pump			5/7/2007	4,214	108	39	108		396	32
33	Faucet			5/16/2007	1,425	37	39	37		134	33
34	Pump Motor			5/24/2007	910	23	39	23		86	34
35	Paint & Supplies			6/1/2007	8,833	226	39	226		812	35
36	Air Handler			6/4/2007	6,160	158	39	158		566	36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BELHAVEN NURSING & REHABILITATION CENTER # 0048215 Report Period Beginning: 1/1/10 Ending: 12/31/10

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	
37	Wall Protection & Corner Guards	6/27/2007	$ 7,957	$ 204	39	$ 204	$	$ 731	37
38	Paint & Supplies	7/1/2007	4,744	122	39	122		426	38
39	Paint & Supplies	8/1/2007	5,247	135	39	135		460	39
40	Electric Work	8/2/2007	5,438	139	39	139		476	40
41	A/C	8/8/2007	2,534	65	39	65		222	41
42	Paint & Supplies	9/1/2007	4,393	113	39	113		375	42
43	Paint & Supplies	10/1/2007	6,499	167	39	167		542	43
44	Lights, Wall Protection, Draperies	10/9/2007	29,587	759	39	759		2,466	44
45	Shower Valve	11/1/2007	3,650	94	39	94		296	45
46	Paint & Supplies	11/1/2007	3,076	79	39	79		250	46
47	Electric Work	11/9/2007	10,269	263	39	263		834	47
48	Wall Covering	11/28/2007	3,161	81	39	81		257	48
49	Hydraulic Valve	11/28/2007	4,207	108	39	108		342	49
50	Paint & Supplies	12/1/2007	2,065	53	39	53		168	50
51	Kickplates/Wallcoverings	1/11/2008	3,130	80	39	80		241	51
52	Kickplates/Wallcoverings	4/24/2008	4,179	107	39	107		295	52
53	Wallpaper	1/11/2008	1,537	39	39	39		118	53
54	Sheeting	11/21/2008	1,111	28	39	28		62	54
55	Plumbing	6/10/2008	2,410	62	39	62		160	55
56	Water Heater parts replacement	5/13/2008	1,231	32	39	32		84	56
57	A/C Maintenance	5/15/2005	231	6	39	6		16	57
58	Valve Replacement	5/13/2008	3,650	94	39	94		250	58
59	A/C	5/22/2008	2,198	56	39	56		150	59
60	Air Vent	6/5/2008	813	21	39	21		54	60
61	Cooling Tower	6/20/2008	4,093	105	39	105		271	61
62	Freezer parts replacement	9/23/2008	1,208	31	39	31		72	62
63	Water Heater parts replacement	12/5/2008	1,516	39	39	39		81	63
64	Water Heater parts replacement	12/24/2008	969	25	39	25		52	64
65	Electrical	10/22/2008	655	17	39	17		38	65
66	Dining Room	1/15/2008	3,600	92	39	92		277	66
67	Paint/Remodel	2/5/2008	2,300	59	39	59		172	67
68	2nd Floor Paint/Remodel	4/4/2008	3,000	77	39	77		212	68
69	3rd Floor Paint/Remodel	5/16/2008	3,500	90	39	90		239	69
70	TOTAL (lines 4 thru 69)		$ 5,803,623	$ 148,811		$ 148,811	$	$ 664,367	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number BELHAVEN NURSING & REHABILITATION CENTER # 0048215 Report Period Beginning: 1/1/10 Ending: 12/31/10

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 12A, Carried Forward		$ 5,803,623	$ 148,811		$ 148,811	$	$ 664,367	1
2	Paint/Remodel	5/22/2008	1,500	38	39	38		103	2
3	Concrete Work	6/6/2008	300	8	39	8		20	3
4	Remodel - Cabinets/Light Fixtures	9/12/2008	600	15	39	15		36	4
5	Remodel - Cabinets/Light Fixtures	9/12/2008	1,400	36	39	36		84	5
6	Remodel Supplies	10/14/2008	600	15	39	15		35	6
7	Remodel Supplies	1/15/2008	252	6	39	6		19	7
8	Remodel Supplies	2/5/2008	269	7	39	7		20	8
9	Remodel Supplies	4/14/2008	406	10	39	10		29	9
10	Remodel Supplies	4/21/2008	663	17	39	17		47	10
11	Remodel Supplies	4/23/2008	489	13	39	13		34	11
12	Remodel Supplies	5/16/2008	326	8	39	8		22	12
13	Remodel Supplies	5/22/2008	465	12	39	12		32	13
14	Remodel Supplies	9/11/2008	1,106	28	39	28		66	14
15	Remodel Supplies	9/2/2008	1,470	38	39	38		88	15
16	Remodel Supplies	9/12/2008	606	16	39	16		36	16
17	Elevator	4/10/2008	3,006	77	39	77		212	17
18	Elevator	7/21/2008	5,538	142	39	142		355	18
19	Elevator	12/26/2008	4,407	113	39	113		235	19
20	Sprinkler Repairs	7/31/2008	537	14	39	14		34	20
21	Sprinkler Repairs	8/28/2008	653	17	39	17		40	21
22	Sprinkler Repairs	8/29/2008	1,510	39	39	39		94	22
23	Sprinkler Repairs	8/31/2008	1,980	51	39	51		123	23
24	Sprinkler Repairs	8/31/2008	1,156	30	39	30		72	24
25	Doors	11/18/2008	350	9	39	9		19	25
26	Doors	11/20/2008	447	11	39	11		25	26
27	Paint/Remodel	10/6/2009	659	17	39	17		21	27
28	Floor Tile	8/19/2009	23,845	611	39	611		866	28
29	Refrigeration Repairs	1/1/2009	1,079	28	39	28		55	29
30	Install Pull Chain Damper	3/17/2009	650	17	39	17		31	30
31	Remove and Replace Floor Tile	7/8/2009	3,000	77	39	77		115	31
32	New Tile in Shower Room	9/28/2009	3,000	77	39	77		103	32
33	Install Sheetrock in Shower Room	11/18/2009	3,000	77	39	77		90	33
34	TOTAL (lines 1 thru 33)		$ 5,868,891	$ 150,485		$ 150,485	$	$ 667,528	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number BELHAVEN NURSING & REHABILITATION CENTER # 0048215 Report Period Beginning: 1/1/10 Ending: 12/31/10

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		$ 5,868,891	$ 150,485		$ 150,485	$	$ 667,528	1
2	Install wood paneling, handrails, corner guards	12/30/2009	3,000	77	39	77		83	2
3	Install Doors, Frames, and Glass	10/20/2009	14,489	372	39	372		464	3
4	Remodel Supplies	12/17/2009	779	20	39	20		22	4
5	Remodel Supplies	12/31/2009	168	4	39	4		5	5
6									6
7	New Doors	4/16/2009	910	23	39	23		41	7
8	New Doors	6/3/2009	1,134	29	39	29		46	8
9	Repair Sinkhole, Repair Pavement, Reseal & Restripe Park.	4/3/2009	9,625	247	39	247		432	9
10	New Faucets and Drains	10/7/2009	2,235	57	39	57		72	10
11	New Faucets and Drains	12/28/2009	1,290	33	39	33		36	11
12	New Faucets and Drains	12/21/2009	1,725	44	39	44		48	12
13	New Faucets and Drains	12/21/2009	1,725	44	39	44		48	13
14	New Roofing	9/14/2009	68,755	1,763	39	1,763		2,351	14
15	New Roofing	10/16/2009	1,950	50	39	50		63	15
16	Fix Airconditioning	9/17/2009	1,050	27	39	27		36	16
17	Install and Paint Over Water Lines	6/19/2009	785	20	39	20		32	17
18	Install and Paint Over Water Lines	5/21/2009	1,700	44	39	44		73	18
19	Paint	10/19/2010	605	16	39	4	(12)	4	19
20	Paint	12/20/2010	129	3	39	0	(3)	0	20
21	Paint & Tape	12/21/2010	137	4	39	0	(3)	0	21
22	Paint	12/28/2010	690	18	39	1	(16)	1	22
23	Switches	12/16/2010	86	2	39	0	(2)	0	23
24	Cord, Connector Body, & Receptacles	12/20/2010	105	3	39	0	(2)	0	24
25	Receptacles	12/21/2010	803	21	39	2	(19)	2	25
26	Motor	12/28/2010	106	3	39	0	(2)	0	26
27	Motors	12/28/2010	212	5	39	0	(5)	0	27
28	Batteries, Lamps, & Paint	12/29/2010	245	6	39	1	(6)	1	28
29	Drywall & Construction Supplies	10/13/2010	1,302	33	39	8	(25)	8	29
30									30
31	Removal of Old Dooring & Installation of Dura Glides	12/17/2009	12,315	316	39	316	(0)	316	31
32	Wall Coverings. Wall Tiles, Table Lamps, Ceiling Pendants	12/29/2009	27,050	694	39	694	0	694	32
33	Ceramic Tiles for Floors	12/30/2009	265	7	39	7	(0)	7	33
34	TOTAL (lines 1 thru 33)		$ 6,024,261	$ 154,468		$ 154,373	$ (96)	$ 672,413	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number BELHAVEN NURSING & REHABILITATION CENTER # 0048215 Report Period Beginning: 1/1/10 Ending: 12/31/10

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 12C, Carried Forward		$ 6,024,261	$ 154,468		$ 154,373	$ (96)	$ 672,413	1
2	Chairs, Tables, Artwork, and Window Treatment	1/25/2010	8,153	209	39	209	0	209	2
3	Replacement Tile Flooring & New Curtains	2/15/2010	1,195	31	39	28	(3)	28	3
4	Upholstered Bench	6/22/2010	609	16	39	9	(7)	9	4
5	Replacement Pipe Insulation in the Boiler Room	12/24/2010	1,562	40	39	3	(37)	3	5
6	Compressor Breakers	7/23/2010	1,292	33	39	17	(17)	17	6
7	Shower Remodeling, 2nd Floor	1/20/2010	3,000	77	39	77	(0)	77	7
8	Shower Remodeling, 2nd Floor - Fixing Cracked Tiles	2/3/2010	3,000	77	39	71	(6)	71	8
9	Replacement Ceiling Tiles	12/7/2010	2,750	71	39	6	(65)	6	9
10	Replacement Ceiling Tiles, Paint, Fixing Duct	12/16/2010	2,410	62	39	5	(57)	5	10
11	HUD Inspection Preparation	12/16/2010	8,500	218	39	18	(200)	18	11
12	HUD Inspection Preparation	12/30/2010	6,575	169	39	14	(155)	14	12
13	Mortar & Grout	1/14/2010	165	4	39	4	0	4	13
14	Home Depot	1/15/2010	94	2	39	2	(0)	2	14
15	Mortar & Grout	2/4/2010	523	13	39	12	(1)	12	15
16	Floor Removal & Ceiling Paint/Primer	12/9/2010	535	14	39	1	(13)	1	16
17	Cleaners, Paints, Door Hinges, Flooring	12/16/2010	1,216	31	39	3	(29)	3	17
18	Hardware for Doors/Flooring	12/17/2010	1,746	45	39	4	(41)	4	18
19	Replacement Ceiling Panels	10/25/2010	1,312	34	39	8	(25)	8	19
20	Replacement Ceiling Panels	12/8/2010	941	24	39	2	(22)	2	20
21	Almond Cove Base	12/8/2010	188	5	39	0	(4)	0	21
22	Replacement Ceiling Panels	12/9/2010	20	1	39	0	(0)	0	22
23	Door Stops	12/22/2010	40	1	39	0	(1)	0	23
24	Elevator	8/5/2010	153,000	3,923	39	1,635	(2,288)	1,635	24
25	Sprinklers	9/30/2010	750	19	39	6	(13)	6	25
26	Hinges, Paint, Glass, and Stainless Steel for Basement	6/24/2010	6,115	157	39	91	(65)	91	26
27	Metal Doors Setup	12/9/2010	6,175	158	39	13	(145)	13	27
28	Door Locks	12/14/2010	475	12	39	1	(11)	1	28
29	Circuits, Outlets, Metal Plates, Transformers, Timers	5/25/2010	1,395	36	39	24	(12)	24	29
30	Water Leak Repairs	6/9/2010	2,145	55	39	32	(23)	32	30
31	Replacement Outlets & Switches	12/22/2010	880	23	39	2	(21)	2	31
32	Landscaping/Trees	6/23/2010	2,400	62	39	36	(26)	36	32
33	Doorway Repairs/Supplies	6/23/2010	6,379	164	39	95	(68)	95	33
34	TOTAL (lines 1 thru 33)		$ 6,249,801	$ 160,251		$ 156,803	$ (3,449)	$ 674,843	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number BELHAVEN NURSING & REHABILITATION CENTER # 0048215 Report Period Beginning: 1/1/10 Ending: 12/31/10

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 12D, Carried Forward		$ 6,249,801	$ 160,251		$ 156,803	$ (3,449)	$ 674,843	1
2	Floor Removal & Installation in Office Area	6/22/2010	450	12	39	7	(5)	7	2
3	Lumber	12/15/2010	191	5	39	0	(4)	0	3
4	Inspection Preparation	12/20/2010	600	15	39	1	(14)	1	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
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21									21
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,251,042	$ 160,283		$ 156,811	$ (3,472)	$ 674,852	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number BELHAVEN NURSING & REHABILITATION CE # 0048215 Report Period Beginning: 1/1/10 Ending: 12/31/10

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	$ 497,447	$ 119,955	$ 90,691	$ (29,264)	5	$ 315,842	71
72	Current Year Purchases	92,726	10,592	10,592		5	10,592	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 590,173	$ 130,547	$ 101,283	$ (29,264)		$ 326,434	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)	$	6,941,215	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	290,830	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	258,094	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	(32,736)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	1,001,286	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BELHAVEN NURSING & REHABILITATION CENTER # 0048215 Report Period Beginning: 1/1/10 Ending: 12/31/10

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: *

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	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BELHAVEN NURSING & REHABILITATION CENTER # 0048215 Report Period Beginning: 1/1/10 Ending: 12/31/10

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BELHAVEN NURSING & REHABILITATION CENTER # 0048215 Report Period Beginning: 1/1/10 Ending: 12/31/10

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-3	hrs	$		$ 241,868	$		$ 241,868	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs			154,039			154,039	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs			226,003			226,003	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				290,948		290,948	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Radiology & Lab	39-2					36,781		36,781	13
14	TOTAL			$		$ 621,910	$ 327,729		$ 949,639	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BELHAVEN NURSING & REHABILITATION CENTER # 0048215 Report Period Beginning: 1/1/10 Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/10 (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	$ 70,871	$ 2,724,896	1
2	Cash-Patient Deposits	10,878	10,878	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	4,690,593	4,826,988	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	406,360	406,360	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,178,702	$ 7,969,122	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		100,000	13
14	Buildings, at Historical Cost		5,500,000	14
15	Leasehold Improvements, at Historical Cost	751,041	751,041	15
16	Equipment, at Historical Cost	440,173	590,173	16
17	Accumulated Depreciation (book methods)	(472,949)	(1,203,996)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		4,605,292	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(1,381,586)	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)**	$ 718,265	$ 8,960,924	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,896,967	$ 16,930,046	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 648,609	$ 648,609	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	499,662	499,662	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
	Other Current Liabilities(specify):			
36	Settlement Reserve	375,000	375,000	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,523,271	$ 1,943,271	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,450,000	1,450,000	39
40	Mortgage Payable		10,417,761	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)**	$ 1,450,000	$ 11,867,761	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,973,271	$ 13,811,032	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,923,696	$ 3,119,014	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,896,967	$ 16,930,046	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number BELHAVEN NURSING & REHABILITATION CENTER # 0048215 Report Period Beginning: 1/1/10 Ending: 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,403,160	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,403,160	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,908,159	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	(1,387,623)	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)**	$ 520,536	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)**	$ 2,923,696	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BELHAVEN NURSING & REHABILITATION CI # 0048215 Report Period Beginning: 1/1/10 Ending: 12/31/10

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 12,191,639	1
2	Discounts and Allowances for all Levels	(761,531)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,430,108	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,129,291	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,129,291	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	294,252	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	21,221	19
20	Radiology and X-Ray	4,160	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 319,633	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	54,974	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 54,974	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING INCOME	1,809	28
28a	MISCELLANEOUS REVENUE	88,952	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 90,761	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,024,767	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,702,472	31
32	Health Care	5,304,727	32
33	General Administration	1,754,343	33
	B. Capital Expense		
34	Ownership	1,906,339	34
	C. Ancillary Expense		
35	Special Cost Centers	327,729	35
36	Provider Participation Fee	120,998	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,116,608	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,908,159	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,908,159	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: 1/1/10 Ending: 12/31/10

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,185	2,361	$ 99,347	$ 42.08	1
2	Assistant Director of Nursing					2
3	Registered Nurses	23,836	26,402	859,500	32.55	3
4	Licensed Practical Nurses	49,783	55,029	1,398,591	25.42	4
5	CNAs & Orderlies	131,434	144,763	1,423,844	9.84	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	14,406	15,843	152,979	9.66	9
10	Activity Assistants					10
11	Social Service Workers	5,966	6,446	106,050	16.45	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	26,413	29,023	295,216	10.17	15
16	Dishwashers					16
17	Maintenance Workers	3,711	4,027	67,471	16.75	17
18	Housekeepers	23,651	26,334	265,848	10.10	18
19	Laundry	14,253	15,929	170,428	10.70	19
20	Administrator	2,091	2,195	116,803	53.21	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,655	8,669	133,582	15.41	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)	305,384	337,021	$ 5,089,659 *	$ 15.10	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	429	$ 15,000	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	553	27,661	10-3	38
39	Pharmacist Consultant	478	23,920	15-3	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	77	2,682	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,537	$ 69,263		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

Facility Name & ID Number BELHAVEN NURSING & REHABILITATION CEI # 0048215 Report Period Beginning: 1/1/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
DINO VARANAS	ADMIN	0%	$ 116,803
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 116,803

B. Administrative - Other

Description	Amount
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
MEYER MAGENCE	LEGAL	$ (63)
BRADLEY & ASSOCIATES	ACCOUNTING	9,154
JOHNSON, GOLDBERG…	ACCOUNTING	3,000
INFINITY HEALTHCARE	PROFESSIONAL	290,451
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 302,543

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 111,720
Unemployment Compensation Insurance	119,163
FICA Taxes	386,269
Employee Health Insurance	70,695
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
LIFE INSURANCE	29,028
EMPLOYEE EXPENSE	57,902
PHYSICAL EXPENSE	850
UNIFORM EXPENSE	4,632
TOTAL (agree to Schedule V, line 22, col.8)	$ 780,259

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed ____)	
Patient Background Checks	
LICENSE FEES/DUES	3,313
CLASSIFIED ADS & FILING FEES	497
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,810

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
AUTO ALLOWANCE	7,130
MILEAGE	2,141
Seminar Expense	
BUSINESS SEMINAR EXPENSE	3,830
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 13,101

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BELHAVEN NURSING & REHABILITATION CENTE] # 0048215 Report Period Beginning: 1/1/10 Ending: 12/31/10

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BELHAVEN NURSING & REHABILITATION CENTER # 0048215 Report Period Beginning: 1/1/10 Ending: 12/31/10

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **5 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **87,127** 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. $ **120,998**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **N/A**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.