FOR BHF USE

LL1

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.

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

I. IDPH License ID Number: 0048215

Facility Name: Belhaven Nursing & Rehabilitation Center, LLC

Address: 11401 South Oakley Avenue (Number) Chicago (City) 60643 (Zip Code)

County: Cook

Telephone Number: 773-233-6311 **Fax #** 773-233-9304

HFS ID Number:

Date of Initial License for Current Owners: 07/01/2006

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 1/1/11 to 12/31/11 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, 201 S. Capitol Ave, Suite 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, LLC # 0048215 Report Period Beginning: 1/1/11 Ending: 12/31/11

III. STATISTICAL DATA

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

	1 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	59,855	3,753	7,344	70,952	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	59,855	3,753	7,344	70,952	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.96%

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 07/01/06

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 07/01/06 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 7,219

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: 12/31/2011 Fiscal Year: 12/31/2011

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Belhaven Nursing & Rehabilitation Center, L # 0048215 Report Period Beginning: 1/1/11 Ending: 12/31/11

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	315,246	32,805	15,000	363,051		363,051	(4,063)	358,988			1
2	Food Purchase		324,288		324,288		324,288		324,288			2
3	Housekeeping	249,369	38,818		288,187		288,187		288,187			3
4	Laundry	176,860	25,479		202,339		202,339		202,339			4
5	Heat and Other Utilities			328,446	328,446		328,446	508	328,954			5
6	Maintenance	69,442	50,682	91,909	212,033		212,033	(1,349)	210,684			6
7	Other (specify):*											7
8	TOTAL General Services	810,917	472,072	435,355	1,718,344		1,718,344	(4,904)	1,713,440			8
	B. Health Care and Programs											
9	Medical Director			13,000	13,000		13,000		13,000			9
10	Nursing and Medical Records	3,751,560	564,290	33,700	4,349,550		4,349,550	5,276	4,354,826			10
10a	Therapy			609,143	609,143		609,143		609,143			10a
11	Activities	144,750	25,996		170,746		170,746		170,746			11
12	Social Services	71,428		3,756	75,184		75,184		75,184			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Pharmcay Consultant			15,608	15,608		15,608		15,608			15
16	TOTAL Health Care and Programs	3,967,738	590,286	675,207	5,233,231		5,233,231	5,276	5,238,507			16
	C. General Administration											
17	Administrative	140,789			140,789		140,789		140,789			17
18	Directors Fees											18
19	Professional Services			325,865	325,865		325,865	(279,005)	46,860			19
20	Dues, Fees, Subscriptions & Promotions			9,048	9,048		9,048	275	9,323			20
21	Clerical & General Office Expenses	149,392	79,758	23,361	252,511		252,511	190,495	443,006			21
22	Employee Benefits & Payroll Taxes			821,099	821,099		821,099	8,217	829,316			22
23	Inservice Training & Education											23
24	Travel and Seminar			15,381	15,381		15,381	570	15,951			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			558,966	558,966		558,966	55,752	614,718			26
27	Other (specify):*											27
28	TOTAL General Administration	290,181	79,758	1,753,720	2,123,659		2,123,659	(23,696)	2,099,963			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,068,836	1,142,116	2,864,282	9,075,234		9,075,234	(23,324)	9,051,910			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, LLC #0048215 Report Period Beginning: 1/1/11 Ending: 12/31/11

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			122,073	122,073		122,073	186,315	308,388			30
31	Amortization of Pre-Op. & Org.							307,019	307,019			31
32	Interest			109,739	109,739		109,739	594,809	704,548			32
33	Real Estate Taxes							421,606	421,606			33
34	Rent-Facility & Grounds			1,680,000	1,680,000		1,680,000	(1,665,520)	14,480			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* **Replacement Tax**			28,607	28,607		28,607		28,607			36
37	**TOTAL Ownership**			1,940,419	1,940,419		1,940,419	(155,771)	1,784,648			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		303,658		303,658		303,658		303,658			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**		303,658	120,998	424,656		424,656		424,656			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,068,836	1,445,774	4,925,699	11,440,309		11,440,309	(179,095)	11,261,214			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 Center, LLC # 0048215 Report Period Beginning: 1/1/11 Ending: 12/31/11

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	23,858	30		9
10	Interest and Other Investment Income	(26,381)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(85)	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	(530)	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	(5,131)	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	(25,629)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (33,898)		$	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)	(145,197)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (145,197)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (179,095)		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, LLC

ID# 0048215

Report Period Beginning: 1/1/11

Ending: 12/31/11

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Income	$ (1,453)	6	1
2	Medical Records	(1,639)	10	2
3	Miscellaneous Income	(6,537)	21	3
4	Rebate	(16,000)	10	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**	(25,629)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Belhaven Nursing & Rehabilitation Center, LLC # 0048215 **Report Period Beginning:** 1/1/11 **Ending:** 12/31/11

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	(85)	(3,978)	0	0	0	0	0	0	0	0	0	(4,063)	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	508	0	0	0	0	0	0	0	0	0	508	5
6	Maintenance	(1,453)	104	0	0	0	0	0	0	0	0	0	(1,349)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,538)	(3,366)	0	0	0	0	0	0	0	0	0	(4,904)	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	(17,639)	22,915	0	0	0	0	0	0	0	0	0	5,276	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**	(17,639)	22,915	0	0	0	0	0	0	0	0	0	5,276	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	(299,707)	20,702	0	0	0	0	0	0	0	0	(279,005)	19
20	Fees, Subscriptions & Promotions	0	0	275	0	0	0	0	0	0	0	0	275	20
21	Clerical & General Office Expenses	(12,198)	202,683	10	0	0	0	0	0	0	0	0	190,495	21
22	Employee Benefits & Payroll Taxes	0	8,217	0	0	0	0	0	0	0	0	0	8,217	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	570	0	0	0	0	0	0	0	0	0	570	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	496	55,256	0	0	0	0	0	0	0	0	55,752	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(12,198)	(87,741)	76,243	0	0	0	0	0	0	0	0	(23,696)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(31,375)	(68,192)	76,243	0	0	0	0	0	0	0	0	(23,324)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Belhaven Nursing & Rehabilitation Center, LLC # 0048215 **Report Period Beginning:** 1/1/11 **Ending:** 12/31/11

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	23,858	0	162,457	0	0	0	0	0	0	0	0	186,315	30
31	Amortization of Pre-Op. & Org.	0	0	307,019	0	0	0	0	0	0	0	0	307,019	31
32	Interest	(26,381)	0	621,190	0	0	0	0	0	0	0	0	594,809	32
33	Real Estate Taxes	0	0	421,606	0	0	0	0	0	0	0	0	421,606	33
34	Rent-Facility & Grounds	0	(1,665,520)	0	0	0	0	0	0	0	0	0	(1,665,520)	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	(2,523)	(1,665,520)	1,512,272	0	0	0	0	0	0	0	0	(155,771)	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)	(33,898)	(1,733,712)	1,588,515	0	0	0	0	0	0	0	0	(179,095)	45

Facility Name & ID Number Belhaven Nursing & Rehabilitation Center, LLC # 0048215 Report Period Beginning: 1/1/11 Ending: 12/31/11

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as 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 Wages	$ 15,000	Infinity Healthcare Management		$ 11,022	$ (3,978)	1
2	V	6	Maintenance Wages		Infinity Healthcare Management		446	446	2
3	V	10	Nursing Wages	25,200	Infinity Healthcare Management		48,115	22,915	3
4	V	21	Admin Wages		Infinity Healthcare Management		210,071	210,071	4
5	V	5	Utilities	73	Infinity Healthcare Management		581	508	5
6	V	6	Maintenance	800	Infinity Healthcare Management		458	(342)	6
7	V	19	Professional Fees	300,000	Infinity Healthcare Management		293	(299,707)	7
8	V	21	Office Expense	30,213	Infinity Healthcare Management		22,825	(7,388)	8
9	V	22	Employee Benefits	2,808	Infinity Healthcare Management		11,025	8,217	9
10	V	24	Auto/Travel		Infinity Healthcare Management		570	570	10
11	V	26	Insurance		Infinity Healthcare Management		496	496	11
12	V	34	Rent		Infinity Healthcare Management		14,480	14,480	12
13	V	34	Rent	1,680,000	Belhaven Realty, LLC			(1,680,000)	13
14	Total			$ 2,054,094			$ 320,382	$ * (1,733,712)	14

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

Facility Name & ID Number Belhaven Nursing & Rehabilitation Center, LLC # 0048215 Report Period Beginning: 1/1/11 Ending: 12/31/11

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	21	Bank Service Charge	$	Belhaven Realty, LLC		$ 10	$ 10	15
16	V	30	Depreciation		Belhaven Realty, LLC		162,457	162,457	16
17	V	20	Filing Fees		Belhaven Realty, LLC		275	275	17
18	V	26	Insurance		Belhaven Realty, LLC		55,256	55,256	18
19	V	32	Interest		Belhaven Realty, LLC		621,190	621,190	19
20	V	19	Professional Fees		Belhaven Realty, LLC		20,702	20,702	20
21	V	33	Real Estate Taxes		Belhaven Realty, LLC		421,606	421,606	21
22	V	31	Amortization		Belhaven Realty, LLC		307,019	307,019	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			$			$ 1,588,515	$ * 1,588,515	39

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

Facility Name & ID Number Belhaven Nursing & Rehabilitation Center, LLC # 0048215 Report Period Beginning: 1/1/11 Ending: 12/31/11

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
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								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Belhaven Nursing & Rehabilitation Center, I # 0048215 Report Period Beginning: 1/1/11 Ending: 12/31/11

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		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

Facility Name & ID Number Belhaven Nursing & Rehabilitation Center, LLC # 0048215 Report Period Beginning: 1/1/11 Ending: 12/31/11

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 & Rehabilitation Center, L # 0048215 Report Period Beginning: 1/1/11 Ending: 12/31/11

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	$ 10,313,424	10/24/2043	5.9900	$ 621,190	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Midwest Bank & Trust Co.		x	Working Capital	NONE	07/11/06	3,000,000	3,000,000	12/7/12	5.5000	109,739	6
7												7
8												8
9	TOTAL Facility Related				$105,131.00		$ 13,616,000	$ 13,313,424			$ 730,929	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 13,616,000	$ 13,313,424			$ 730,929	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, LLC **#** 0048215 **Report Period Beginning:** 1/1/11 **Ending:** 12/31/11

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 348,705	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.)		$ 379,078	2
3. Under or (over) accrual (line 2 minus line 1).		$ 30,373	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 391,233	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.		$ 421,606	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2006	368,191	8
2007	364,216	9
2008	368,116	10
2009	377,411	11
2010	379,078	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2010	$	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.**

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Belhaven Nursing & Rehabilitation Center, LLC 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 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	25-19-110-040-0000	Nursing Home	$ 379,077.67	$ 379,077.67
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 379,077.67	$ 379,077.67

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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, LLC # 0048215 Report Period Beginning: 1/1/11 Ending: 12/31/11

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, LLC # 0048215 Report Period Beginning: 1/1/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		$ 6,511,000	$ 141,026	39	$ 166,949	$ 25,923	$ 775,641	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9							39				9
10	Wanderguard Security Camera			7/25/2006	37,000	949	39	949		5,692	10
11							39				11
12							39				12
13							39				13
14	Improvements - Paint & Painting Supplies			10/1/2006	600	15	39	15		92	14
15	2nd Floor Remodeling - Cove Base for Rooms			11/1/2006	1,408	36	39	36		217	15
16	2nd Floor Remodeling - Wall Protection & Corner Guards			11/1/2006	2,372	61	39	61		365	16
17	2nd Floor Remodeling - Floor & Tile			11/1/2006	5,418	139	39	139		834	17
18	2nd Floor Remodeling - Paint & Painting Supplies			11/1/2006	14,919	383	39	383		2,295	18
19	2nd Floor Remodeling - Cove Base, Vertical Dividers, Wood Drift			11/1/2006	2,275	58	39	58		350	19
20	Fast Signs			1/9/2007	3,352	86	39	86		430	20
21							39				21
22							39				22
23	Draperies, Light Fixtures, Cascades			1/23/2007	19,454	499	39	499		2,494	23
24							39				24
25	Painting & Supplies			2/1/2007	1,500	38	39	38		192	25
26	Water Pump & Boiler Tank			2/26/2007	7,156	183	39	183		917	26
27	Paint & Supplies			3/1/2007	2,657	68	39	68		341	27
28	Paint & Supplies			4/1/2007	5,520	142	39	142		708	28
29							39				29
30	Wall Paper, Wall Protection			5/1/2007	7,306	187	39	187		937	30
31	Paint & Supplies			5/1/2007	4,746	122	39	122		608	31
32	Heating & Cooling Pump			5/7/2007	4,214	108	39	108		540	32
33							39				33
34							39				34
35	Paint & Supplies			6/1/2007	8,833	226	39	226		1,132	35
36	Air Handler			6/4/2007	6,160	158	39	158		790	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 Belhaven Nursing & Rehabilitation Center, LLC # 0048215 Report Period Beginning: 1/1/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	$	$ 1,020	37
38	Paint & Supplies	7/1/2007	4,744	122	39	122		608	38
39	Paint & Supplies	8/1/2007	5,247	135	39	135		673	39
40	Electric Work	8/2/2007	5,438	139	39	139		697	40
41	A/C	8/8/2007	2,534	65	39	65		325	41
42	Paint & Supplies	9/1/2007	4,393	113	39	113		563	42
43	Paint & Supplies	10/1/2007	6,499	167	39	167		833	43
44	Lights, Wall Protection, Draperies	10/9/2007	27,168	697	39	697		3,483	44
45	Shower Valve	11/1/2007	3,650	94	39	94		468	45
46	Paint & Supplies	11/1/2007	3,076	79	39	79		394	46
47	Electric Work	11/9/2007	10,269	263	39	263		1,317	47
48	Wall Covering	11/28/2007	3,161	81	39	81		405	48
49	Hydraulic Valve	11/28/2007	4,207	108	39	108		539	49
50	Paint & Supplies	12/1/2007	2,065	53	39	53		265	50
51	Kickplates/Wallcoverings	1/11/2008	3,130	80	39	80		321	51
52	Kickplates/Wallcoverings	4/24/2008	4,179	107	39	107		429	52
53					39				53
54					39				54
55					39				55
56					39				56
57					39				57
58	Valve Replacement	5/13/2008	3,650	94	39	94		374	58
59					39				59
60					39				60
61	Cooling Tower	6/20/2008	4,093	105	39	105		420	61
62					39				62
63	Water Heater parts replacement	12/5/2008	1,516	39	39	39		156	63
64	Water Heater parts replacement	12/24/2008	969	25	39	25		99	64
65					39				65
66	Dining Room	1/15/2008	3,600	92	39	92		369	66
67	Paint/Remodel	2/5/2008	2,300	59	39	59		236	67
68	2nd Floor Paint/Remodel	4/4/2008	3,000	77	39	77		308	68
69	3rd Floor Paint/Remodel	5/16/2008	3,500	90	39	90		359	69
70	TOTAL (lines 4 thru 69)		$ 6,766,235	$ 147,570		$ 173,493	$ 25,923	$ 809,237	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, LLC # 0048215 Report Period Beginning: 1/1/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		$ 6,766,235	$ 147,570		$ 173,493	$ 25,923	$ 809,237	1
2	Paint/Remodel	5/22/2008	1,500	38	39	38		154	2
3					39				3
4	Remodel - Cabinets/Light Fixtures	9/12/2008	600	15	39	15		62	4
5	Remodel - Cabinets/Light Fixtures	9/12/2008	1,400	36	39	36		144	5
6	Remodel Supplies	10/14/2008	600	15	39	15		62	6
7	Remodel Supplies	1/15/2008	252	6	39	6		26	7
8	Remodel Supplies	2/5/2008	269	7	39	7		28	8
9	Remodel Supplies	4/14/2008	406	10	39	10		42	9
10	Remodel Supplies	4/21/2008	663	17	39	17		68	10
11	Remodel Supplies	4/23/2008	489	13	39	13		50	11
12	Remodel Supplies	5/16/2008	326	8	39	8		33	12
13	Remodel Supplies	5/22/2008	465	12	39	12		48	13
14	Remodel Supplies	9/11/2008	1,106	28	39	28		113	14
15	Remodel Supplies	9/2/2008	1,470	38	39	38		151	15
16	Remodel Supplies	9/12/2008	606	16	39	16		62	16
17	Elevator	4/10/2008	3,006	77	39	77		308	17
18	Elevator	7/21/2008	5,538	142	39	142		568	18
19	Elevator	12/26/2008	4,407	113	39	113		452	19
20	Sprinkler Repairs	7/31/2008	537	14	39	14		55	20
21	Sprinkler Repairs	8/28/2008	653	17	39	17		67	21
22	Sprinkler Repairs	8/29/2008	1,510	39	39	39		155	22
23	Sprinkler Repairs	8/31/2008	1,980	51	39	51		203	23
24	Sprinkler Repairs	8/31/2008	1,156	30	39	30		119	24
25					39				25
26					39				26
27					39				27
28	Floor Tile	8/19/2009	23,845	611	39	611		1,834	28
29					39				29
30					39				30
31	Remove and Replace Floor Tile	7/8/2009	3,000	77	39	77		231	31
32	New Tile in Shower Room	9/28/2009	3,000	77	39	77		231	32
33	Install Sheetrock in Shower Room	11/18/2009	3,000	77	39	77		231	33
34	TOTAL (lines 1 thru 33)		$ 6,828,018	$ 149,155		$ 175,078	$ 25,923	$ 814,731	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, LLC # 0048215 Report Period Beginning: 1/1/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		$ 6,828,018	$ 149,155		$ 175,078	$ 25,923	$ 814,731	1
2	Install wood paneling, handrails, corner guards	12/30/2009	3,000	77	39	77		231	2
3	Install Doors, Frames, and Glass	10/20/2009	14,489	372	39	372		1,115	3
4					39				4
5					39				5
6					39				6
7	New Doors	4/16/2009	910	23	39	23		70	7
8	New Doors	6/3/2009	1,134	29	39	29		87	8
9	Repair Sinkhole, Repair Pavement, Reseal & Restripe Park.	4/3/2009	9,625	247	39	247		740	9
10	New Faucets and Drains	10/7/2009	2,235	57	39	57		172	10
11	New Faucets and Drains	12/28/2009	1,290	33	39	33		99	11
12	New Faucets and Drains	12/21/2009	1,725	44	39	44		133	12
13	New Faucets and Drains	12/21/2009	1,725	44	39	44		133	13
14	New Roofing	9/14/2009	68,755	1,763	39	1,763		5,289	14
15	New Roofing	10/16/2009	1,950	50	39	50		150	15
16					39				16
17	Install and Paint Over Water Lines	6/19/2009	785	20	39	20		60	17
18	Install and Paint Over Water Lines	5/21/2009	1,700	44	39	44		131	18
19					39				19
20					39				20
21					39				21
22					39				22
23					39				23
24					39				24
25					39				25
26					39				26
27					39				27
28					39				28
29	Drywall & Construction Supplies	10/13/2010	1,302	33	39	33		67	29
30					39				30
31	Removal of Old Dooring & Installation of Dura Glides	12/17/2009	12,315	316	39	316		947	31
32	Wall Coverings. Wall Tiles, Table Lamps, Ceiling Pendants	12/29/2009	25,004	641	39	641		1,923	32
33					39				33
34	TOTAL (lines 1 thru 33)		$ 6,975,962	$ 152,948		$ 178,871	$ 25,923	$ 826,078	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, LLC # 0048215 Report Period Beginning: 1/1/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		$ 6,975,962	$ 152,948		$ 178,871	$ 25,923	$ 826,078	1
2					39				2
3					39				3
4					39				4
5					39				5
6					39				6
7	Shower Remodeling, 2nd Floor	1/20/2010	3,000	77	39	77		154	7
8	Shower Remodeling, 2nd Floor - Fixing Cracked Tiles	2/3/2010	3,000	77	39	77		154	8
9	Replacement Ceiling Tiles	12/7/2010	2,750	71	39	71		141	9
10	Replacement Ceiling Tiles, Paint, Fixing Duct	12/16/2010	2,410	62	39	62		124	10
11					39				11
12					39				12
13					39				13
14					39				14
15					39				15
16					39				16
17	Cleaners, Paints, Door Hinges, Flooring	12/16/2010	1,216	31	39	31		62	17
18	Hardware for Doors/Flooring	12/17/2010	1,746	45	39	45		90	18
19					39				19
20					39				20
21					39				21
22					39				22
23					39				23
24	Elevator	8/5/2010	153,000	3,923	39	3,923		11,613	24
25					39				25
26	Hinges, Paint, Glass, and Stainless Steel for Basement	6/24/2010	6,115	157	39	157		314	26
27	Metal Doors Setup	12/9/2010	6,175	158	39	158		317	27
28	Door Locks	12/14/2010	475	12	39	12		24	28
29					39				29
30					39				30
31					39				31
32					39				32
33					39				33
34	TOTAL (lines 1 thru 33)		$ 7,155,850	$ 157,561		$ 183,484	$ 25,923	$ 839,070	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, LLC # 0048215 Report Period Beginning: 1/1/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		$ 7,155,850	$ 157,561		$ 183,484	$ 25,923	$ 839,070	1
2					39				2
3					39				3
4					39				4
5	Concrete Work	9/27/2011	11,000	282	39	71	(211)	282	5
6	Concrete & Asphalt Work	9/27/2011	6,750	173	39	43	(130)	173	6
7	Asphalt Work	11/12/2011	1,575	40	39	7	(33)	40	7
8	Fire Alarm System Devices	5/27/2011	8,506	218	39	127	(91)	218	8
9	HUD Inspection Preparation	1/5/2011	5,325	137	39	137	0	137	9
10	Sprinkler Addition in Elevator Pit	9/27/2011	2,575	66	39	17	(49)	66	10
11	New Hydronic Heater	1/24/2011	5,470	140	39	140	(0)	140	11
12	Chiller Compressor Replacement	4/20/2011	10,300	264	39	176	(88)	264	12
13					39	45	45		13
14	Chiller & Cooling Tower Cleaning	5/4/2011	7,950	204	39	136	(68)	204	14
15	New Cooling Tower Fan Motor Pulley & Blower Belts	7/6/2011	4,318	111	39	55	(56)	111	15
16	Kitchen Air Handler	8/2/2011	1,245	32	39	13	(19)	32	16
17					39	403	403		17
18	Sewer Dig Up & Repair	6/9/2011	10,500	269	39	157	(112)	269	18
19	Replaced Broken Pipe& Filled Holes w/ Concrete	7/6/2011	5,200	133	39	67	(66)	133	19
20	Remodel Offices- Ceiling Tiles, Flooring, Lighting, Paint	11/30/2011	8,486	218	39	18	(200)	218	20
21	Remodel Nurses Stations- Lighting, Coffered Ceiling, Floor				39				21
22	Tile, New Work Stations, Sink, Paint	11/30/2011	107,949	2,768	39	231	(2,537)	2,768	22
23	Remodel Corridors- Lighting, Floor Tile, Ceiling Tile,				39				23
24	Wallcovering, Handrail, Corner Gauards, Paint Doors	11/30/2011	315,993	8,102	39	225	(7,877)	8,102	24
25	Remodel Dining Rooms- Lighting, Drywall, Floor Tile, Ceiling				39				25
26	Tile, Paint, Wallcoverings, Corner Gaurds, Roller Shades	11/30/2011	112,227	2,878	39	240	(2,638)	2,878	26
27	Remodel PT Room- Lighting, Tile, Paint, Cabinets, Countertops	11/30/2011	36,356	932	39	78	(854)	932	27
28	Elevators- New Flooring, Wall Panels, Wall Base, Ceiling	11/30/2011	18,834	483	39	40	(443)	483	28
29	Specialty Consultation re: Safety Code Surveys	6/20/2011	2,905	74	39	43	(31)	74	29
30	Develop Fires Saftey Evaluation System	8/25/2011	5,278	135	39	45	(90)	135	30
31	Ceiling Panel	1/3/2011	547	14	39	14	(0)	14	31
32	Smoke Damper	2/1/2010	3,900	100	39	92	(8)	100	32
33	Insulated Unit	1/12/2011	760	19	39	19	(0)	19	33
34	TOTAL (lines 1 thru 33)		$ 7,849,799	$ 175,354		$ 186,123	$ 10,768	$ 856,864	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, LLC # 0048215 Report Period Beginning: 1/1/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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 12E, Carried Forward		$ 7,849,799	$ 175,354		$ 186,123	$ 10,768	$ 856,864	1
2	Insulated Unit	1/25/2011	705	18	39	17	(1)	17	2
3	Building Light	11/11/2011	710	18	39	3	(15)	18	3
4	Metal Door	1/3/2011	6,560	168	39	168	(0)	168	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	TOTAL (lines 1 thru 33)		$ 7,857,774	$ 175,559		$ 186,311	$ 10,752	$ 857,067	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, LLC # 0048215 Report Period Beginning: 1/1/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	$ 614,501	$ 29,036	$ 111,537	$ 82,501	5	$ 546,437	71
72	Current Year Purchases	77,186	77,186	10,540	(66,646)	5	77,186	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 691,687	$ 106,222	$ 122,077	$ 15,855		$ 623,623	75

D. Vehicle Costs. (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)	$ 8,649,461	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 281,781	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 308,388	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 26,607	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,480,690	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.

Facility Name & ID Number Belhaven Nursing & Rehabilitation Center, LLC # 0048215 Report Period Beginning: 1/1/11 Ending: 12/31/11

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								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.	/2012	$
13.	/2013	$
14.	/2014	$

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, LLC # 0048215 Report Period Beginning: 1/1/11 Ending: 12/31/11

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, LLC # 0048215 Report Period Beginning: 1/1/11 Ending: 12/31/11

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-3	hrs	$		$ 241,797	$		$ 241,797	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs			125,451			125,451	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs			241,895			241,895	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				292,335		292,335	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Radilogy & Lab	39-2					11,323		11,323	12
13	Other (specify):									13
14	TOTAL			$		$ 609,143	$ 303,658		$ 912,801	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

STATE OF ILLINOIS

Facility Name & ID Number Belhaven Nursing & Rehabilitation Center, LLC # 0048215 **Report Period Beginning:** 1/1/11 **Ending:** 12/31/11

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/11 (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	$ (64,074)	$ 865,569	1
2	Cash-Patient Deposits	(9,366)	(9,366)	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	8,086,504	8,283,905	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	608,572	608,572	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)**	$ 8,621,636	$ 9,748,680	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	1,478,314	1,478,314	15
16	Equipment, at Historical Cost	517,355	667,355	16
17	Accumulated Depreciation (book methods)	(595,023)	(1,488,526)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		4,605,292	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(1,688,606)	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)**	$ 1,400,646	$ 9,173,829	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 10,022,282	$ 18,922,509	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,145,438	$ 2,145,438	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	553,817	553,817	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	Settlement Reserve	375,000	375,000	36
37	Working Capital Loan	3,000,000	3,000,000	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 6,074,255	$ 6,074,255	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		10,313,424	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)**	$	$ 10,313,424	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,074,255	$ 16,387,679	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,948,027	$ 2,534,830	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 10,022,282	$ 18,922,509	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Belhaven Nursing & Rehabilitation Center, LLC # 0048215 **Report Period Beginning:** 1/1/11 **Ending:** 12/31/11

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,923,696	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,923,696	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,224,310	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	(1,200,600)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **prior yr adjustments**	621	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,024,331	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)**	$ 3,948,027	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Belhaven Nursing & Rehabilitation Center, LLC # 0048215 Report Period Beginning: 1/1/11 Ending: 12/31/11

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	$ 13,061,707	1
2	Discounts and Allowances for all Levels	(898,674)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 12,163,033	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,174,887	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,174,887	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	270,073	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	20,559	19
20	Radiology and X-Ray	5,466	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 296,098	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	26,381	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 26,381	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	vending income	1,454	28
28a	miscellaneous revenue	2,766	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,220	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,664,619	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,718,344	31
32	Health Care	5,233,231	32
33	General Administration	2,123,659	33
	B. Capital Expense		
34	Ownership	1,940,419	34
	C. Ancillary Expense		
35	Special Cost Centers	303,658	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)***	$ 11,440,309	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,224,310	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,224,310	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, LLC # 0048215 Report Period Beginning: 1/1/11 Ending: 12/31/11

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	1,944	2,160	$ 102,958	$ 47.67	1
2	Assistant Director of Nursing					2
3	Registered Nurses	21,906	24,297	773,846	31.85	3
4	Licensed Practical Nurses	50,436	54,891	1,448,515	26.39	4
5	CNAs & Orderlies	125,173	136,270	1,364,092	10.01	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	11,911	13,143	144,750	11.01	9
10	Activity Assistants					10
11	Social Service Workers	6,010	6,640	116,116	17.49	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	27,233	29,622	315,246	10.64	15
16	Dishwashers					16
17	Maintenance Workers	3,969	4,338	69,442	16.01	17
18	Housekeepers	21,283	23,562	249,369	10.58	18
19	Laundry	16,137	17,442	176,860	10.14	19
20	Administrator	2,777	2,937	140,789	47.94	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,881	7,553	104,703	13.86	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	3,928	4,548	62,150	13.67	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	299,588	327,403	$ 5,068,836 *	$ 15.48	34

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		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	170	8,500	10-3	38
39	Pharmacist Consultant	312	15,608	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	107	3,756	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	589	$ 27,864		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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number Belhaven Nursing & Rehabilitation Center, LLC # 0048215 Report Period Beginning: 1/1/11 Ending: 12/31/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Dino Varnavas	Admin	0	$ 124,858
Thomeka Brown	Asst Admin	0	15,931
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 140,789

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
Swanson, Martin	Legal	$ 3,548
Stahl Cowen Crowley	Legal	500
Infinity Healthcare	Professional	300,000
Bradley Associates	Accounting	18,817
Johnson, Goldberg & Brown	Accounting	3,000
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 325,865

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 139,601
Unemployment Compensation Insurance	172,835
FICA Taxes	377,128
Employee Health Insurance	85,683
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Uniforms	1,832
Employee Expense	51,355
TOTAL (agree to Schedule V, line 22, col.8)	$ 828,434

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	$ 3,980
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
State of IL	25
Secretary of State	250
City of Chicago	4,568
Other License/Dues	500
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,323

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Auto Allowance	12,203
Mileage	693
Seminar Expense	
Education	2,688
Travel	321
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 15,905

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Belhaven Nursing & Rehabilitation Center, LLC # 0048215 Report Period Beginning: 1/1/11 Ending: 12/31/11

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, LLC # 0048215 Report Period Beginning: 1/1/11 Ending: 12/31/11

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.

(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. $ **122,890** 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?
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.