

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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: <u>0044768</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																																																			
Facility Name: <u>Maryhaven Nursing & Rehabilitation</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/2011</u> to <u>6/30/2012</u> 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.																																																																																			
Address: <u>1700 East Lake Avenue</u> <u>Glenview</u> <u>60025</u>																																																																																					
Number City Zip Code																																																																																					
County: <u>Cook</u>																																																																																					
Telephone Number: <u>(847) 729-1300</u> Fax # <u>(847) 729-9620</u>																																																																																					
HFS ID Number: _____		<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td><td><u>10/30/2012</u></td></tr><tr><td>(Type or Print Name) <u>Mike Volante</u></td><td>(Date)</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Title) <u>System Director - Reimbursement</u></td><td></td></tr><tr><td>(Signed) _____</td><td><u>10/30/2012</u></td></tr><tr><td>(Print Name and Title) <u>Patrick Szajkovics</u> <u>Senior Consultant</u></td><td>(Date)</td></tr><tr><td>(Firm Name & Address) <u>Strategic Reimbursement, Inc.</u> <u>360 W. Butterfield Road, Suite 310, Elmhurst, IL 60126</u></td><td></td></tr><tr><td colspan="2"></td><td>(Telephone) <u>(630) 530-7100</u></td><td>Fax # <u>(630) 530-7106</u></td></tr><tr><td colspan="2">Date of Initial License for Current Owners: <u>03/01/2000</u></td><td colspan="2" rowspan="5"> 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 </td></tr><tr><td colspan="2">Type of Ownership:</td></tr><tr><td colspan="2"><table><tr><td>☒</td><td>VOLUNTARY, NON-PROFIT</td><td>☐</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☒</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td></td><td></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td></td><td></td><td>☐</td><td>"Sub-S" Corp.</td><td>☐</td><td>_____</td></tr><tr><td></td><td></td><td>☐</td><td>Limited Liability Co.</td><td>☐</td><td>_____</td></tr><tr><td></td><td></td><td>☐</td><td>Trust</td><td>☐</td><td>_____</td></tr><tr><td></td><td></td><td>☐</td><td>Other _____</td><td>☐</td><td>_____</td></tr></table></td></tr><tr><td colspan="2">IRS Exemption Code <u>501(c)(3)</u></td></tr><tr><td colspan="2">In the event there are further questions about this report, please contact:</td></tr><tr><td colspan="2">Name: <u>Patrick Szajkovics, SRI</u> Telephone Number: <u>(630) 530-7100, Ext. 111</u></td></tr><tr><td colspan="2">Email Address: _____</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	<u>10/30/2012</u>	(Type or Print Name) <u>Mike Volante</u>	(Date)	Paid Preparer	(Title) <u>System Director - Reimbursement</u>		(Signed) _____	<u>10/30/2012</u>	(Print Name and Title) <u>Patrick Szajkovics</u> <u>Senior Consultant</u>	(Date)	(Firm Name & Address) <u>Strategic Reimbursement, Inc.</u> <u>360 W. Butterfield Road, Suite 310, Elmhurst, IL 60126</u>				(Telephone) <u>(630) 530-7100</u>	Fax # <u>(630) 530-7106</u>	Date of Initial License for Current Owners: <u>03/01/2000</u>		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		Type of Ownership:		<table><tr><td>☒</td><td>VOLUNTARY, NON-PROFIT</td><td>☐</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☒</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td></td><td></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td></td><td></td><td>☐</td><td>"Sub-S" Corp.</td><td>☐</td><td>_____</td></tr><tr><td></td><td></td><td>☐</td><td>Limited Liability Co.</td><td>☐</td><td>_____</td></tr><tr><td></td><td></td><td>☐</td><td>Trust</td><td>☐</td><td>_____</td></tr><tr><td></td><td></td><td>☐</td><td>Other _____</td><td>☐</td><td>_____</td></tr></table>		☒	VOLUNTARY, NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL	☒	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County			☐	Corporation	☐	Other _____			☐	"Sub-S" Corp.	☐	_____			☐	Limited Liability Co.	☐	_____			☐	Trust	☐	_____			☐	Other _____	☐	_____	IRS Exemption Code <u>501(c)(3)</u>		In the event there are further questions about this report, please contact:		Name: <u>Patrick Szajkovics, SRI</u> Telephone Number: <u>(630) 530-7100, Ext. 111</u>		Email Address: _____	
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Facility Name & ID Number Maryhaven Nursing & Rehabilitation# 0044768 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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 bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>135</u>	Skilled (SNF)	<u>135</u>	<u>49,410</u>	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	<u>135</u>	TOTALS	<u>135</u>	<u>49,410</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>4,407</u>		<u>5,292</u>	<u>9,699</u>	8
9	SNF/PED					9
10	ICF	<u>17,667</u>	<u>12,856</u>	<u>225</u>	<u>30,748</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>22,074</u>	<u>12,856</u>	<u>5,517</u>	<u>40,447</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 81.86%

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?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒ NO ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 03/01/00

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 03/01/00 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 135 and days of care provided 3,993Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 6/30/12 Fiscal Year: 6/30/12

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	435,157	42,084	15,968	493,209		493,209		493,209			1
2	Food Purchase		309,619		309,619		309,619	(28,175)	281,444			2
3	Housekeeping	200,443	79	288	200,810		200,810		200,810			3
4	Laundry	110,593	67,196		177,789		177,789	(19,412)	158,377			4
5	Heat and Other Utilities			149,326	149,326		149,326		149,326			5
6	Maintenance	104,035	16,759	150,882	271,676		271,676		271,676			6
7	Other (specify):*											7
8	TOTAL General Services	850,228	435,737	316,464	1,602,429		1,602,429	(47,587)	1,554,842			8
	B. Health Care and Programs											
9	Medical Director			29,500	29,500		29,500		29,500			9
10	Nursing and Medical Records	2,905,936	114,340	39,302	3,059,578		3,059,578	(14,269)	3,045,309			10
10a	Therapy	292,777	4,534	7,197	304,508		304,508		304,508			10a
11	Activities	145,478	8,281	682	154,441		154,441	(48)	154,393			11
12	Social Services	121,945	1,559	6,429	129,933		129,933		129,933			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,466,136	128,714	83,110	3,677,960		3,677,960	(14,317)	3,663,643			16
	C. General Administration											
17	Administrative	108,929		918,443	1,027,372		1,027,372		1,027,372			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions			22,687	22,687		22,687		22,687			20
21	Clerical & General Office Expenses	723,913	70,536	(133,571)	660,878		660,878	138,839	799,717			21
22	Employee Benefits & Payroll Taxes			1,510,149	1,510,149		1,510,149		1,510,149			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			853	853		853		853			25
26	Insurance-Prop.Liab.Malpractice			221,234	221,234		221,234		221,234			26
27	Other (specify):*											27
28	TOTAL General Administration	832,842	70,536	2,539,795	3,443,173		3,443,173	138,839	3,582,012			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,149,206	634,987	2,939,369	8,723,562		8,723,562	76,935	8,800,497			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			563,182	563,182		563,182		563,182			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			150,344	150,344		150,344		150,344			32
33	Real Estate Taxes			112,263	112,263		112,263	(112,263)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			46,287	46,287		46,287		46,287			35
36	Other (specify):*											36
37	TOTAL Ownership			872,076	872,076		872,076	(112,263)	759,813			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		746,778		746,778		746,778	14,269	761,047			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			346,874	346,874		346,874		346,874			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		746,778	346,874	1,093,652		1,093,652	14,269	1,107,921			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,149,206	1,381,765	4,158,319	10,689,290		10,689,290	(21,059)	10,668,231			45

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(28,175)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(19,412)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(17,796)	21		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	44,324			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (21,059)		\$	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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (21,059)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

STATE OF ILLINOIS
Maryhaven Nursing & Rehabilitation

Page 5A

ID# 0044768
Report Period Beginning: 7/1/2011
Ending: 6/30/2012

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Miscellaneous Revenue Offset	\$ (7,135)	21	1
2	Miscellaneous Auxiliary Revenue Offset	(27,430)	21	2
3	Real Estate Taxes	(112,263)	33	3
4	Reverse Charity Care Credit exp adj from Hospital	191,200	21	4
5	Activities Marketing and Advertising Cost	(48)	11	5
6				6
7	Lab Expense - Reclass Outside Services	(14,269)	10	7
8	Lab Expense - Reclass Outside Services	14,269	39	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
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44				44
45				45
46				46
47				47
48				48
49	Total	44,324		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Maryhaven Nursing & Rehabilitation# 0044768

Report Period Beginning:

7/1/2011

Ending:

6/30/2012

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(28,175)	0	0	0	0	0	0	0	0	0	0	(28,175)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(19,412)	0	0	0	0	0	0	0	0	0	0	(19,412)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(47,587)	0	0	0	0	0	0	0	0	0	0	(47,587)	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	(14,269)	0	0	0	0	0	0	0	0	0	0	(14,269)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(48)	0	0	0	0	0	0	0	0	0	0	(48)	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	(14,317)	0	0	0	0	0	0	0	0	0	0	(14,317)	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	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	138,839	0	0	0	0	0	0	0	0	0	0	138,839	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	138,839	0	0	0	0	0	0	0	0	0	0	138,839	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	76,935	0	0	0	0	0	0	0	0	0	0	76,935	29

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	(112,263)	0	0	0	0	0	0	0	0	0	0	(112,263)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(112,263)	0	0	0	0	0	0	0	0	0	0	(112,263)	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	14,269	0	0	0	0	0	0	0	0	0	0	14,269	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	14,269	0	0	0	0	0	0	0	0	0	0	14,269	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(21,059)	0	0	0	0	0	0	0	0	0	0	(21,059)	45

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
Resurrection Health Care	100	Resurrection Senior Services	Des Plaines	See PG 6-Supp attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Administration	\$ 918,443	Resurrection Health Care Corporation	100.00%	\$ 918,443		1
2	V	30	Depreciation	114,891	Resurrection Health Care Corporation	100.00%	114,891		2
3	V	32	Interest Expense	150,344	Resurrection Health Care Corporation	100.00%	150,344		3
4	V	39	Pharmacy	746,778	Resurrection Health Care Corporation	100.00%	746,778		4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,930,456			\$ 1,930,456	\$ *	14

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

Facility Name & ID Number

Maryhaven Nursing & Rehabilitation

0044768

Report Period Beginning:

7/1/2011

Ending:

6/30/2012

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	Resurrection Health Care Corp.	100 %	Resurrection Senior Services	Chicago	Provena-Resurrection	Chicago	Health Care	1
2					Resurrection University	Oak Park	Health Care	2
3					Holy Family Health Care	Des Plaines	Health Care	3
4					Holy Family Medical Center	Des Plaines	Health Care	4
5					Mt. Loretto Nursing Home	Amsterdam	Senior Living	5
6					Our Lady of the Resurrection	Chicago	Health Care	6
7					Provena Care & Home	Mokena	Health Care	7
8					Provena Health	Frankfort	Health Care	8
9					Provena Home Health	Mokena	Health Care	9
10					Provena Hospitals	Frankfort	Health Care	10
11					Provena Laverna Terrace	Mokena	Health Care	11
12					Provena Self Insurance	Frankfort	Insurance	12
13					Provena Senior Services	Mokena	Health Care	13
14					Provena Family Services	Broadview	Health Care	14
15					Resurrection Ambulatory	Chicago	Health Care	15
16					Resurrection Development	Des Plaines	Fundraising	16
17					Resurrection Health Care	Des Plaines	Health Care	17
18					Resurrection Home Health	Morton Grove	Home Care	18
19					Resurrection Medical Center	Chicago	Health Care	19
20					Resurrection Medical Center	Chicago	Fundraising	20
21					Resurrection Ministries	Castleton	Parent Corp	21
22					Resurrection Nursing	Castleton	Senior Living	22
23					Resurrection Services	Chicago	Health Care	23
24					Saint Francis Hospital	Evanston	Health Care	24
25					Saint Francis Hospital	Evanston	Fundraising	25
26					Saint Mary and Elizabeth	Chicago	Health Care	26
27					St. Joseph Hospital	Chicago	Health Care	27
28								28
29								29
30								30

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	John Walton - Thru 10/31/11	BOD						1
2	Sr. Donna Marie Wolowicki to 9/30/11	BOD						2
3	Nicola Byrne thru 12/16/11	BOD						3
4	Demetrios Kouzios thru 12/1/11	BOD						4
5	Connie March - effective 11/1/11	BOD						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 Maryhaven Nursing & Rehabilitation # 0044768 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Maryhaven Nursing & Rehabilitation # 0044768 Report Period Beginning: 7/1/2011 Ending: 7/30/2012

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

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

Name of Related Organization Resurrection Health Care
Street Address 100 North River Road
City / State / Zip Code Des Plaines, Illinois 60016
Phone Number (847) 813-3719
Fax Number (847) 813-3786

	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	17	Administration	Cost Charged per TB	1	1	\$ 918,443	\$	1	\$ 918,443	1
2	30	Depreciation	Cost Charged per TB	1	1	114,891		1	114,891	2
3	32	Interest Expense	Cost Charged per TB	1	1	150,344		1	150,344	3
4	39	Pharmacy	Cost Charged per TB	1	1	746,778		1	746,778	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					\$ 1,930,456	\$		\$ 1,930,456	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
	A. Directly Facility Related Long-Term													
1	Allocated from Home Office						\$	\$			\$	150,344	1	
2													2	
3													3	
4													4	
5													5	
	Working Capital													
6	N/A												6	
7													7	
8													8	
9	TOTAL Facility Related						\$	\$				\$	150,344	9
	B. Non-Facility Related*													
10	N/A												10	
11													11	
12													12	
13													13	
14	TOTAL Non-Facility Related						\$	\$				\$		14
15	TOTALS (line 9+line14)						\$	\$				\$	150,344	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.)

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

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

B. Real Estate Taxes

	Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1. Real Estate Tax accrual used on 2011 report.	\$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$		2
3. Under or (over) accrual (line 2 minus line 1).	\$		3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)	\$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$		7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:			
	2007		8
	2008		9
	2009		10
	2010		11
	2011		12
<u>Facility is a not-for-profit and does not pay real estate taxes for the main property</u>			

		FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	\$		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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME
Maryhaven Nursing & Rehabilitation

COUNTY
Cook

FACILITY IDPH LICENSE NUMBER
0044768

CONTACT PERSON REGARDING THIS REPORT
Michael Gordon, Business Unit CFO

TELEPHONE
(708) 478-7911
FAX #:
(708) 478-5387

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

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

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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.**

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Resident Care	83,762	2000	\$ 2,935,798	1
2					2
3	TOTALS	83,762		\$ 2,935,798	3

Facility Name & ID Number Maryhaven Nursing & Rehabilitation

0044768

Report Period Beginning:

7/1/2011

Ending:

6/30/2012

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	135		2000	1961	\$ 5,932,922	\$ 197,764	30	\$ 197,764	\$	\$ 2,440,584	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		2000		57,015	3,268	10-15	3,268		45,577	9
10	Various		2001		1,157,971	71,816	10-20	71,816		884,582	10
11	Various		2002		527,735	30,946	10-15	30,946		458,044	11
12	Various		2003		1,428	95	15	95		809	12
13	Various		2004		1,760	117	15	117		997	13
14	Various		2005		61,382	4,958	5- 20	4,958		45,624	14
15	Various		2006		107,161	10,890	7-15	10,890		68,664	15
16	Various		2007		2,310	289	8	289		1,588	16
17											17
18	Sump Drains, Installation and Wiring		2008		73,448	3,672	20	3,672		16,526	18
19											19
20	ComEd Program - Lighting Retrofit Project		2009		16,263	1,626	10	1,626		4,066	20
21	Code Alert Wanderer System		2009		7,721	1,103	7	1,103		2,757	21
22											22
23	Installatn-New Wood like Flring &Tiling in 7 rms & Hallwy		2011		4,598	230	10	230		230	23
24	Sheet Vinyl Wall Protector for Patient Rooms		2011		2,450	123	10	123		123	24
25	Installatn-New Wood like Flring &Tiling in 7 rms & Hallwy		2011		11,756	588	10	588		588	25
26	Installatn-New Wood like Flring &Tiling in 7 rms & Hallwy		2011		10,934	547	10	547		547	26
27	Skimcoat 2 Cinderblk walls& Prep/Paint 11 rooms		2011		9,680	968	5	968		968	27
28	MHNR Pvt Rm Remodel; Shades, Valence,cubicle curtains		2011		15,401	1,540	5	1,540		1,540	28
29	Additional Tiling During Revovations		2011		2,811	141	10	141		141	29
30											30
31	Install New Main Kitchen Doors,Keypads & Operators		2012		11,595	386	15	386		386	31
32	Excavate & install 2 storm lines to nearest catch basin		2012		4,980	100	25	100		100	32
33	Install W-786 on Wall & Elev side of doors in Passngr Elev		2012		2,170	109	10	109		109	33
34	Install Belbien on Walls in Freight Elevator		2012		6,300	315	10	315		315	34
35	New Floor Finishing in Units C & G		2012		1,380	69	10	69		69	35
36	Repairs to Fire Alarm System per Glenview Village Inspection		2012		5,800	290	10	290		290	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

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			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66	Financial Statement Depreciation Adjustments (rounding)			(3)		(3)		7	66
67	Home office allocation			114,891		114,891			67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 8,036,971	\$ 446,838		\$ 446,838	\$	\$ 3,975,231	70

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

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	\$2,398,481	\$116,344	\$116,344	\$	5-20	\$1,758,357	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$2,398,481	\$116,344	\$116,344	\$		\$1,758,357	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	Resident Care	Ford E350 Van	2001	\$5,030	\$	\$	\$		\$5,030	76
77										77
78										78
79										79
80	TOTALS			\$5,030	\$	\$	\$		\$5,030	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$13,376,280	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$563,182	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$563,182	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$5,738,618	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	CIP (Accrued Assets)	\$4,626	92
93			93
94			94
95		\$4,626	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
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:	N/A			\$			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
- N/A

9. Option to Buy:
- ☐ YES☐ NO
- Terms: *

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

15. Is Movable equipment rental included in building rental?
- ☐ YES☒ NO
16. Rental Amount for movable equipment: \$46,287
- Description: Copiers and Medical Equipment - See Page 14A for a breakdown.
(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	N/A		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2013	\$
13.	/2014	\$
14.	/2015	\$

* 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.

Provider Number: 0044768

FYE: 6/30/2012

Attachment to Schedule XII, Line 16- Equipment Rental Cost

Sub Acct 7020

<u>Equipment</u>	<u>Amount</u>
Copiers & Printers	10,183
Postal Meter	1,576
Satellite TV	5,067
Other Admin Equipment	<u>1,704</u>
Sub-total Admin acct 9000-	18,530
Therapeutic Medical Equipment	17,233
Other Medical Equipment	<u>10,524</u>
Sub-Total Medical Equipment acct 90140-	27,757
Total - Rental Equipment Costs	<u><u>46,287</u></u>

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
☒ NO

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

The CNAs that were hired were already trained.

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.

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 (1 & 3)	2430 hrs	\$ 108,672		\$	\$	2,430	\$ 108,672	1
2	Licensed Speech and Language Development Therapist	10A (1 & 3)	538 hrs	17,434				538	17,434	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A (1 & 3)	2608 hrs	120,009				2,608	120,009	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				746,778		746,778	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): COTA	10A (3)			59	3,790		59	3,790	12
13	Other (specify): PTA	10A (3)			64	3,379		64	3,379	13
14	TOTAL			\$ 246,115	123	\$ 7,169	\$ 746,778	5,699	\$ 1,000,062	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.

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	\$ 75,821	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 790,787)	2,350,729		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	10,355		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,436,905	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	2,935,798		13
14	Buildings, at Historical Cost	8,798,555		14
15	Leasehold Improvements, at Historical Cost	83,952		15
16	Equipment, at Historical Cost	1,492,883		16
17	Accumulated Depreciation (book methods)	(5,671,222)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	69,720		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(67,396)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 7,642,290	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,079,195	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 745,722	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	110,000		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due To OLR	19,926		36
37	Due To RMC	3,902,940		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,778,588	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,778,588	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 5,300,607	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 10,079,195	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 7,068,542	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 7,068,542	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,767,935)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,767,935)	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)	\$ 5,300,607	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Maryhaven Nursing & Rehabilitation# 0044768Report Period Beginning: 7/1/2011Ending: 6/30/2012

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

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

	1		2
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 12,470,508	1
2	Discounts and Allowances for all Levels	(3,632,700)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,837,808	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	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	28,175	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	19,412	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 47,587	23
	D. Non-Operating Revenue		
24	Contributions	1,395	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,395	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Income-See Offset on PG 5A	7,135	28
28a	Misc. Income-See Offset on PG 5A	27,430	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 34,565	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,921,355	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,602,429	31
32	Health Care	3,677,960	32
33	General Administration	3,443,173	33
	B. Capital Expense		
34	Ownership	872,076	34
	C. Ancillary Expense		
35	Special Cost Centers	746,778	35
36	Provider Participation Fee	346,874	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,689,290	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,767,935)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,767,935)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 3,528,148	44
45	Private Pay - Net Inpatient Revenue	3,280,400	45
46	Medicare - Net Inpatient Revenue	2,029,260	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,837,808	49

* 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.

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

Facility Name & ID Number Maryhaven Nursing & Rehabilitation# 0044768Report Period Beginning: 7/1/2011Ending: 6/30/2012

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,788	2,031	\$ 98,852	\$ 48.67	1
2	Assistant Director of Nursing	1,840	1,983	84,037	42.38	2
3	Registered Nurses	36,028	39,772	1,401,668	35.24	3
4	Licensed Practical Nurses	5,831	6,633	182,371	27.49	4
5	CNAs & Orderlies	89,158	97,121	1,395,550	14.37	5
6	CNA Trainees					6
7	Licensed Therapist	7,145	7,942	292,761	36.86	7
8	Rehab/Therapy Aides	2,374	2,586	31,935	12.35	8
9	Activity Director	1,881	2,155	53,156	24.67	9
10	Activity Assistants	6,985	7,973	93,096	11.68	10
11	Social Service Workers	2,887	3,231	77,624	24.02	11
12	Dietician	714	770	15,657	20.33	12
13	Food Service Supervisor	3,804	4,349	103,269	23.75	13
14	Head Cook	5,688	6,339	93,059	14.68	14
15	Cook Helpers/Assistants	18,416	21,469	236,080	11.00	15
16	Dishwashers					16
17	Maintenance Workers	4,177	4,589	104,835	22.84	17
18	Housekeepers	12,717	14,659	155,759	10.63	18
19	Laundry	10,604	11,941	147,935	12.39	19
20	Administrator	1,842	2,142	108,929	50.85	20
21	Assistant Administrator					21
22	Other Administrative	9,687	11,114	191,780	17.26	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care MDS Coordntr	5,684	6,497	231,336	35.61	32
33	Other(specify) <u>Chaplain</u>	1,479	1,820	49,517	27.21	33
34	TOTAL (lines 1 - 33)	230,729	257,116	\$ 5,149,206 *	\$ 20.03	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	29,500	9 (3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 29,500		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

STATE OF ILLINOIS

Facility Name & ID Number

Maryhaven Nursing & Rehabilitation

0044768

Report Period Beginning:

7/1/2011

Page 21

Ending:

6/30/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions				
Name		Function	Ownership %	Amount	Description		Amount	Description		Amount		
Sara J. Szumski		Administrator	0	\$ 108,929	Workers' Compensation Insurance		\$ 49,635	IDPH License Fee		\$		
					Unemployment Compensation Insurance		13,095	Advertising: Employee Recruitment				
					FICA Taxes		371,724	Health Care Worker Background Check				
					Employee Health Insurance		753,892	(Indicate # of checks performed)				
					Employee Meals			Patient Background Checks				
					Illinois Municipal Retirement Fund (IMRF)*			IL Council of LTC dues		10,929		
					Retirement		270,690	Joint Commission		1,285		
					Disability		19,361	Allscripts		2,315		
					Life Insurance		8,934	Life Service Network of ILL		2,666		
					Tuition Reimbursement		17,184	Other Misc Dues/Subscriptions		5,492		
					Empl Assistance Program / Other		5,634	Less: Public Relations Expense		()		
								Non-allowable advertising		()		
								Yellow page advertising		()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 108,929	TOTAL (agree to Schedule V, line 22, col.8)				\$ 1,510,149	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 22,687
B. Administrative - Other					E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
Description			Amount	Description		Line #	Amount	Description		Amount		
Management Exp - Fees Paid To Home Office (See Sch. VII)			\$ 918,443	N/A			\$	Out-of-State Travel		\$		
								N/A				
								In-State Travel				
								N/A				
								Seminar Expense				
								N/A				
								Entertainment Expense		()		
								(agree to Sch. V, line 24, col. 8)				
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$ 918,443	TOTAL				\$	TOTAL		\$
C. Professional Services												
Vendor/Payee		Type	Amount									
N/A			\$									
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				\$								

* Attach copy of IMRF notifications

**See instructions.

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

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

XX. GENERAL INFORMATION:

- | | |
|--|---|
| <p>(1) Are nursing employees (RN,LPN,NA) represented by a union? <u>No</u></p> <p>(2) Are there any dues to nursing home associations included on the cost report? <u>Yes</u>
If YES, give association name and amount. <u>Illinois Council of LTC \$ 10929</u></p> <p>(3) Did the nursing home make political contributions or payments to a political action organization? <u>No</u> If YES, have these costs been properly adjusted out of the cost report? <u>N/A</u></p> <p>(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? <u>No</u> If YES, what is the capacity? <u>N/A</u></p> <p>(5) Have you properly capitalized all major repairs and equipment purchases? <u>Yes</u>
What was the average life used for new equipment added during this period? <u>12 yrs</u></p> <p>(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ <u>13,647</u> Line <u>10 (2)</u></p> <p>(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>Yes</u> If NO, attach a complete explanation.</p> <p>(8) Are you presently operating under a sale and leaseback arrangement? <u>No</u>
If YES, give effective date of lease. <u>N/A</u></p> <p>(9) Are you presently operating under a sublease agreement? YES <u>X</u> NO</p> <p>(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
<u>N/A</u></p> <p>(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ <u>346,874</u>
This amount is to be recorded on line 42 of Schedule V.</p> <p>(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? <u>No</u> If YES, attach an explanation of the allocation.</p> | <p>(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? <u>Yes</u></p> <p>(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? <u>No</u> 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.</p> <p>(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ <u>0</u> Has any meal income been offset against related costs? <u>Yes</u> Indicate the amount. \$ <u>28,175</u></p> <p>(16) Travel and Transportation
a. Are there costs included for out-of-state travel? <u>No</u>
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>No</u> If YES, please indicate the amount of income earned from such a program during this reporting period. \$ <u>N/A</u>
c. What percent of all travel expense relates to transportation of nurses and patients? <u>100%</u>
d. Have vehicle usage logs been maintained? <u>Adequate records are maintained.</u>
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>Yes</u>
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? <u>N/A</u>
g. Does the facility transport residents to and from day training? <u>No</u>
Indicate the amount of income earned from providing such transportation during this reporting period. \$ <u>N/A</u></p> <p>(17) Has an audit been performed by an independent certified public accounting firm? <u>Yes</u>
Firm Name: <u>KPMG, LLP</u></p> <p>(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? <u>Yes</u></p> <p>(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? <u>N/A</u>
Attach invoices and a summary of services for all architect and appraisal fees.</p> |
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