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: 0050088

Facility Name: NILES NURSING & REHABILITATION

Address: 9777 GREENWOOD (Number) NILES (City) 60714 (Zip Code)

County: COOK

Telephone Number: (847) 470-0000 **Fax #** (847) 967-5462

HFS ID Number:

Date of Initial License for Current Owners: 6/20/08

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 1/1/2011 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 ACCOUNTANT'S REPORT ATTACHED (Date)
(Print Name and Title) DANIEL S. GAAFAR, PARTNER
(Firm Name & Address) BRADLEY & ASSOCIATES, INC., 201 S. CAPITOL AVE, STE 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 NILES NURSING & REHABILITATION # 0050088 Report Period Beginning: 1/1/2011 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 N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	152	Skilled (SNF)	152	55,480	1
2		Skilled Pediatric (SNF/PED)			2
3	15	Intermediate (ICF)	152	55,480	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	167	TOTALS	304	110,960	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	39,565	654	5,211	45,430	8
9	SNF/PED					9
10	ICF	49,193	1,448		50,641	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	88,758	2,102	5,211	96,071	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.58%

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 6/20/08

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 6/20/08 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 304 and days of care provided 5,167

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/11 Fiscal Year: 12/31/11

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number NILES NURSING & REHABILITATION # 0050088 Report Period Beginning: 1/1/2011 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	477,314	55,472	15,000	547,786		547,786	(3,816)	543,970			1
2	Food Purchase		535,808		535,808		535,808	(409)	535,399			2
3	Housekeeping	335,428	72,111		407,539		407,539		407,539			3
4	Laundry	119,252	35,003		154,255		154,255		154,255			4
5	Heat and Other Utilities			347,233	347,233		347,233	520	347,753			5
6	Maintenance							(3,850)	(3,850)			6
7	Other (specify):*	84,343	28,888	54,063	167,294		167,294		167,294			7
8	**TOTAL General Services**	1,016,337	727,282	416,296	2,159,915		2,159,915	(7,555)	2,152,360			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	4,692,221	421,840	25,200	5,139,261		5,139,261	16,956	5,156,217			10
10a	Therapy			662,918	662,918		662,918		662,918			10a
11	Activities	269,946	45,097		315,043		315,043		315,043			11
12	Social Services	174,550		14,577	189,127		189,127		189,127			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Pharmacy Consultant			21,277	21,277		21,277		21,277			15
16	**TOTAL Health Care and Programs**	5,136,717	466,937	747,972	6,351,626		6,351,626	16,956	6,368,582			16
	C. General Administration											
17	Administrative	87,045			87,045		87,045		87,045			17
18	Directors Fees											18
19	Professional Services			372,939	372,939		372,939	(236,779)	136,160			19
20	Dues, Fees, Subscriptions & Promotions			13,632	13,632		13,632		13,632			20
21	Clerical & General Office Expenses	301,767	112,998	19,578	434,343		434,343	184,057	618,400			21
22	Employee Benefits & Payroll Taxes			1,090,702	1,090,702		1,090,702	8,749	1,099,451			22
23	Inservice Training & Education											23
24	Travel and Seminar			30,469	30,469		30,469	581	31,050			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			215,676	215,676		215,676	20,484	236,160			26
27	Other (specify):*											27
28	**TOTAL General Administration**	388,812	112,998	1,742,996	2,244,806		2,244,806	(22,908)	2,221,898			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,541,866	1,307,217	2,907,264	10,756,347		10,756,347	(13,507)	10,742,840			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 NILES NURSING & REHABILITATION #0050088 Report Period Beginning: 1/1/2011 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			65,551	65,551		65,551	(3,356)	62,195			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			57,242	57,242		57,242	(107)	57,135			32
33	Real Estate Taxes							674,209	674,209			33
34	Rent-Facility & Grounds			3,600,000	3,600,000		3,600,000	(1,637,295)	1,962,705			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			3,722,793	3,722,793		3,722,793	(966,549)	2,756,244			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		206,220		206,220		206,220		206,220			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			166,440	166,440		166,440		166,440			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		206,220	166,440	372,660		372,660		372,660			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,541,866	1,513,437	6,796,497	14,851,800		14,851,800	(980,056)	13,871,744			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 NILES NURSING & REHABILITATION # 0050088 Report Period Beginning: 1/1/2011 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	(2,598)	30		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	(59)	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				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	(40,217)	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	(16,156)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (59,030)		$	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)	(920,268)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (920,268)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (979,298)		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

NILES NURSING & REHABILITATION

ID# 0050088

Report Period Beginning: 1/1/2011

Ending: 12/31/11

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	VENDING INCOME	$ (4,072)	6	1
2	MISCELLANEOUS REVENUE	(5,162)	21	2
3	MEDICAL RECORDS INCOME	(6,922)	10	3
4	NON ALLOWABLE DEPR PER XIX	(758)	30	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**	(16,914)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number NILES NURSING & REHABILITATION # 0050088 **Report Period Beginning:** 1/1/2011 **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	(59)	(3,757)	0	0	0	0	0	0	0	0	0	(3,816)	1
2	Food Purchase	0	(409)	0	0	0	0	0	0	0	0	0	(409)	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	520	0	0	0	0	0	0	0	0	0	520	5
6	Maintenance	(4,072)	222	0	0	0	0	0	0	0	0	0	(3,850)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(4,131)	(3,424)	0	0	0	0	0	0	0	0	0	(7,555)	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	(6,922)	23,878	0	0	0	0	0	0	0	0	0	16,956	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**	(6,922)	23,878	0	0	0	0	0	0	0	0	0	16,956	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	(305,701)	68,922	0	0	0	0	0	0	0	0	(236,779)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(45,379)	228,258	1,178	0	0	0	0	0	0	0	0	184,057	21
22	Employee Benefits & Payroll Taxes	0	8,749	0	0	0	0	0	0	0	0	0	8,749	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	581	0	0	0	0	0	0	0	0	0	581	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	20,484	0	0	0	0	0	0	0	0	0	20,484	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(45,379)	(47,629)	70,100	0	0	0	0	0	0	0	0	(22,908)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(56,432)	(27,175)	70,100	0	0	0	0	0	0	0	0	(13,507)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number NILES NURSING & REHABILITATION # 0050088 **Report Period Beginning:** 1/1/2011 **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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(3,356)	0	0	0	0	0	0	0	0	0	0	(3,356)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	(107)	0	0	0	0	0	0	0	0	(107)	32
33	Real Estate Taxes	0	0	674,209	0	0	0	0	0	0	0	0	674,209	33
34	Rent-Facility & Grounds	0	(1,637,295)	0	0	0	0	0	0	0	0	0	(1,637,295)	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	(3,356)	(1,637,295)	674,102	0	0	0	0	0	0	0	0	(966,549)	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)	(59,788)	(1,664,470)	744,202	0	0	0	0	0	0	0	0	(980,056)	45

Facility Name & ID Number NILES NURSING & REHABILITATION # 0050088 Report Period Beginning: 1/1/2011 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
SEE ATTACHMENT 1						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	$ 15,000	INFINITY HEALTHCARE MANAGEMENT	46.25%	$ 11,243	$ (3,757)	1
2	V	2	RAW FOOD	409	INFINITY HEALTHCARE MANAGEMENT			(409)	2
3	V	5	UTILITIES	73	INFINITY HEALTHCARE MANAGEMENT		593	520	3
4	V	6	MAINTENANCE	700	INFINITY HEALTHCARE MANAGEMENT		922	222	4
5	V	10	NURSING	25,200	INFINITY HEALTHCARE MANAGEMENT		49,078	23,878	5
6	V	19	PROFESSIONAL SERVICES	306,000	INFINITY HEALTHCARE MANAGEMENT		299	(305,701)	6
7	V	21	OFFICE EXPENSE	9,295	INFINITY HEALTHCARE MANAGEMENT		237,553	228,258	7
8	V	22	LIFE INSURANCE	2,497	INFINITY HEALTHCARE MANAGEMENT		11,246	8,749	8
9	V	24	TRAVEL		INFINITY HEALTHCARE MANAGEMENT		581	581	9
10	V	26	LIABILITY INSURANCE		INFINITY HEALTHCARE MANAGEMENT		506	506	10
11	V	34	RENT		INFINITY HEALTHCARE MANAGEMENT		14,770	14,770	11
12	V	34	RENT	3,600,000	NILES NURSING REALTY		1,947,935	(1,652,065)	12
13	V	26	PROPERTY INSURANCE		NILES NURSING REALTY		19,978	19,978	13
14	Total			$ 3,959,174			$ 2,294,704	$ * (1,664,470)	14

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

Facility Name & ID Number NILES NURSING & REHABILITATION # 0050088 Report Period Beginning: 1/1/2011 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 CHARGES	$	NILES NURSING REALTY		$ 1,178	$ 1,178	15
16	V	19	PROFESSIONAL FEES		NILES NURSING REALTY		68,922	68,922	16
17	V	33	TAXES		NILES NURSING REALTY		674,209	674,209	17
18	V	32	INTEREST		NILES NURSING REALTY		(107)	(107)	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 744,202	$ * 744,202	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number NILES NURSING & REHABILITATION # 0050088 Report Period Beginning: 1/1/2011 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

ATTACHMENT #1

OWNERS

NAME	OWNERSHIP %
MICHAEL BLISKO	40.000%
MOISHE GUBIN	40.000%
A&F GENERAL PARTNERSHIP	20.000%
	100.000%

OTHER RELATED BUSINESS ENTITIES

NAME	CITY	TYPE OF BUSINESS
INFINITY HEALTHCARE MANAGEMENT	HILLSIDE, IL	MANAGEMENT CO.

NOTE: INFINITY HEALTHCARE MANAGEMENT IS OWNED BY MOISHE GUBIN AND MICHAEL BLISKO.

Facility Name & ID Number NILES NURSING & REHABILITATION # 0050088 Report Period Beginning: 1/1/2011 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 NILES NURSING & REHABILITATION # 0050088 Report Period Beginning: 1/1/2011 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 NILES NURSING & REHABILITATION # 0050088 Report Period Beginning: 1/1/2011 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**		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							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	BANK LEUMI USA		X	WORKING CAPITAL	NONE	7/18/08	3,000,000	2,722,000	7/16/12	Variable	57,242	6
7												7
8												8
9	TOTAL Facility Related						$ 3,000,000	$ 2,722,000			$ 57,242	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,000,000	$ 2,722,000			$ 57,242	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 NILES NURSING & REHABILITATION # 0050088 **Report Period Beginning:** 1/1/2011 **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.**	$ 195,700	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.)		$ 981,708	2
3. Under or (over) accrual (line 2 minus line 1).		$ 786,008	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ (111,799)	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.		$ 674,209	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2006		8
2007	568,970	9
2008	581,250	10
2009	668,938	11
2010	613,791	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 NILES NURSING & REHABILITATION COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0050088

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.	09-11-306-005-0000	NURSING FACILITY	$ 240,204.88	$ 240,204.88
2.	09-11-306-006-0000	NURSING FACILITY	$ 240,124.06	$ 240,124.06
3.	09-11-306-013-0000	NURSING FACILITY	$ 133,462.48	$ 133,462.48
4.	09-11-306-006-0000	NURSING FACILITY	$ 143,994.94	$ 143,994.94
5.	09-11-306-013-0000	NURSING FACILITY	$ 79,876.23	$ 79,876.23
6.	09-11-306-005-0000	NURSING FACILITY	$ 144,044.99	$ 144,044.99
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 981,707.58	$ 981,707.58

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 NILES NURSING & REHABILITATION # 0050088 Report Period Beginning: 1/1/2011 Ending: 12/31/11

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: N/A B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (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 [ ] (b) Rent equipment from a Related Organization. [X] (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 [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number NILES NURSING & REHABILITATION # 0050088 Report Period Beginning: 1/1/2011 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	304				$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Signs			2008	271	7	39	7		28	9
10	Signs			2008	8,184	210	39	210		839	10
11	Sprinkler Installation			2008	2,305	59	39	59		236	11
12	Fire Alarm Repairs			2008	1,701	44	39	44		174	12
13	Install Sign			2008	8,315	213	39	213		853	13
14	Prep Work for Sign Install			2008	2,800	72	39	72		287	14
15	Smoke Damper			2008	2,150	55	39	55		221	15
16	Boiler Pump Maintenance			2008	1,106	28	39	28		113	16
17	A/C - Water Chiller			2008	1,164	30	39	30		119	17
18	A/C - Unit Repair			2008	970	25	39	25		99	18
19	Fire Dampers			2008	5,543	142	39	142		569	19
20	Fixed Boiler for Hot Water			2008	1,348	35	39	35		138	20
21	A/C Compressor			2008	12,764	327	39	327		1,309	21
22	Freezer Repairs			2008	980	25	39	25		101	22
23	New Motor for Heater, Fix Pump, Boiler			2008	5,493	141	39	141		563	23
24	Hot Water Heater Repairs			2008	908	23	39	23		93	24
25	Freezer Repairs			2008	1,030	26	39	26		106	25
26	Dish Installation - Cable			2008	9,000	231	39	231		923	26
27	Cleared Short - Elevator			2008	754	19	39	19		77	27
28	Replaced Shorting Bar			2008	347	9	39	9		36	28
29	New Button for Elevator			2008	618	16	39	16		63	29
30	New Relay for Elevator			2008	300	8	39	8		31	30
31	New Door Contractor for Elevator			2008	685	18	39	18		70	31
32	New Contractors/Relays for Elevator			2008	1,157	30	39	30		119	32
33	Elevator Hydraulic Packing			2008	1,400	36	39	36		144	33
34	Elevator Hydraulic Oil, Seals, Rings			2008	5,190	133	39	133		532	34
35	Laundry Room Door Installation			2008	1,430	37	39	37		147	35
36	3rd Floor Exit Door			2008	1,323	34	39	34		119	36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number NILES NURSING & REHABILITATION # 0050088 Report Period Beginning: 1/1/2011 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	Stop Strip for Door	2008	$ 774	$ 20	39	$ 20	$	$ 79	37
38	Door Replacement Parts	2008	940	24	39	24		96	38
39	Door Alarm Systems	2008	2,067	53	39	53		212	39
40	Door Control Service Electric Work	2008	828	21	39	21		85	40
41	Painting 2nd Floor	2009	4,250	109	39	109		327	41
42	Painting 2nd Floor	2009	3,700	95	39	95		285	42
43	Paint Doors	2009	800	21	39	21		62	43
44	Remodeling/Painting Supplies	2009	455	12	39	12		35	44
45	Painting	2009	3,500	90	39	90		269	45
46	Painting	2009	3,500	90	39	90		269	46
47	Painting	2009	3,900	100	39	100		300	47
48	Painting	2009	3,500	90	39	90		269	48
49	Painting	2009	3,900	100	39	100		300	49
50	Floor Tiles	2009	5,904	151	39	151		454	50
51	Kitchen Doors	2009	1,500	38	39	38		115	51
52	Removate Hallways	2009	6,000	154	39	154		462	52
53	Renovate Lobby Floors	2009	4,060	104	39	104		312	53
54									54
55	Fire Protection Sprinler Work	2009	45,518	1,167	39	1,167		3,501	55
56	Fire Protection Sprinler Work	2009	59,483	1,525	39	1,525		4,576	56
57	Install Exhaust Fan	2009	500	13	39	13		38	57
58	Relocate Drain Pipes	2009	2,525	65	39	65		194	58
59	Install Wiring & Pipes	2009	1,350	35	39	35		104	59
60	Install Wiring	2009	1,585	41	39	41		122	60
61	Install Windows	2009	1,300	33	39	33		100	61
62	Remove and Install New A/C	2009	38,840	996	39	996		2,988	62
63	A/C Installation	2009	2,392	61	39	61		184	63
64	A/C Installation	2009	2,200	56	39	56		169	64
65	Install Floor Tiles	2009	7,200	185	39	185		554	65
66	Furnishing of Signage	2009	2,218	57	39	57		171	66
67	Fire Sprinkler	2009	1,445	37	39	37		111	67
68	Painting	2009	3,500	90	39	90		269	68
69	Install Extra Insulation	2010	1,105	28	39	28		57	69
70	TOTAL (lines 4 thru 69)		$ 299,975	$ 7,692		$ 7,692	$	$ 25,180	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number NILES NURSING & REHABILITATION # 0050088 Report Period Beginning: 1/1/2011 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		$ 299,975	$ 7,692		$ 7,692	$	$ 25,180	1
2	Remove and Replaced Existing Carpet Tile	2010	573	15	39	15		29	2
3	Grain Quarry Tile Materials and Freight	2010	797	20	39	20		41	3
4	Paint Nursing Station and Baseboards	2010	830	21	39	21		43	4
5	Freeyer Floor and Dishwasher Sink	2010	530	14	39	14		27	5
6	Patched/Painted Walls, Handrails, Double Doors	2010	3,200	82	39	82		164	6
7	Granite and Paint Supplies	2010	710	18	39	18		36	7
8	Painting on 3rd and 4th Floor	2010	1,635	42	39	42		84	8
9	Marble Tile and Labor	2010	1,000	26	39	26		51	9
10	Install Toilet Bowls	2010	327	8	39	8		17	10
11	Install Toilet Bowls	2010	327	8	39	8		17	11
12	Removed and Installed New Carpet	2010	1,500	38	39	38		77	12
13	Install New Kitchen Tiles	2010	1,174	30	39	30		60	13
14	Tuckpointing	2010	2,215	57	39	57		114	14
15	Paint	2010	1,887	48	39	48		97	15
16	Paint and Semi-Gloss	2010	661	17	39	17		34	16
17	Paint	2010	661	17	39	17		34	17
18	Paint and Primer	2010	818	21	39	21		42	18
19	Paint	2010	758	19	39	19		39	19
20	Painting & Wallpapering	2010	1,556	40	39	40		80	20
21	Replaced Compressor and Labor	2010	9,500	244	39	244		487	21
22	Install New High Pressure Sodium Light Fixture	2010	880	23	39	23		45	22
23	New Venolation Air Handler	2010	1,050	27	39	27		54	23
24	Repair & Replace Hot Gas Line	2010	6,050	155	39	155		310	24
25	Repair & Repave Sidewalks & Parking Lot	2010	30,390	779	39	779		1,558	25
26	Install New Showers and & Water system	2011	154,527	3,962	39	2,641	(1,321)	3,962	26
27	Replace Lighting	2011	1,185	30	39	8	(23)	30	27
28	Repair Main Electrical Distribution Box, Install New Outlets & Sv	2011	8,950	229	39	134	(95)	229	28
29	Fix Small Steamer and Mount Wire & Install Circulating A/C Pur	2011	4,230	108	39	63	(45)	108	29
30	Replace Compressor on Air Conditioning Chiller	2011	11,624	298	39	174	(124)	298	30
31	Replace Ignition Control On Boilers	2011	1,103	28	39	9	(19)	28	31
32	Repair & Seal Power Line Shaft & Remove Rust and Reapir Wall	2011	5,750	147	39	98	(49)	147	32
33	Modernize Two 5 Stop Passenger Elevators	2011	143,386	3,677	39	3,677	0	3,677	33
34	TOTAL (lines 1 thru 33)		$ 699,759	$ 17,943		$ 16,266	$ (1,677)	$ 37,201	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number NILES NURSING & REHABILITATION # 0050088 Report Period Beginning: 1/1/2011 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		$ 699,759	$ 17,943		$ 16,266	$ (1,677)	$ 37,201	1
2	Modernize Two 5 Stop Passenger Elevators	2011	104,672	2,684	39	1,118	(1,566)	2,684	2
3	Paint & Materials for First Floor Renevations	2011	654	17	39	15	(1)	17	3
4	Install New Tile, Sand & Paint Walls, Replace Plumbing	2011	3,850	99	39	99	0	99	4
5	Install New Floor, Move Electrical Outlers, Install Chair Rail	2011	6,280	161	39	81	(80)	161	5
6	Install Sprinkler Heads in Laundry Room	2011	925	24	39	18	(6)	24	6
7	Recharge Antifreeze System/Change OS&Y Valve	2011	2,998	77	39	6	(70)	77	7
8	Retrofit Lights	2011	40,064	1,027	39	770	(257)	1,027	8
9	Recharge Antifreeze System, Refill Freon, Repair A/C	2011	34,518	885	39	516	(369)	885	9
10	Replace Doors & Locks	2011	517	13	39	13	(0)	13	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
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32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 894,236	$ 22,929		$ 18,903	$ (4,026)	$ 42,187	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number NILES NURSING & REHABILITATION # 0050088 Report Period Beginning: 1/1/2011 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	$ 176,794	$ 33,549	$ 13,286	$ (20,263)	5	$ 69,265	71
72	Current Year Purchases	98,562	8,856	30,764	21,908	5	8,856	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 275,356	$ 42,405	$ 44,050	$ 1,645		$ 78,121	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)	$ 1,169,592	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 65,334	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 62,953	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (2,381)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 120,308	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 NILES NURSING & REHABILITATION # 0050088 Report Period Beginning: 1/1/2011 Ending: 12/31/11

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NILES NURSING REALTY
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. [X] 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:		304	3/31/10	$ 1,947,935	25		3
4	Additions							4
5								5
6								6
7	TOTAL		304		$ 1,947,935 **			7

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	$ 1,947,935
13.	/2013	$ 1,947,935
14.	/2014	$ 1,947,935

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: [X] YES [ ] NO Terms: *

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] 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 NILES NURSING & REHABILITATION # 0050088 Report Period Beginning: 1/1/2011 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 NILES NURSING & REHABILITATION # 0050088 Report Period Beginning: 1/1/2011 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	$		$ 198,743	$		$ 198,743	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs			228,594			228,594	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs			235,581			235,581	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-3	# of prescrpts				198,387		198,387	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): RADIOLOGY & LAB	39-3					7,833		7,833	13
14	TOTAL			$		$ 662,918	$ 206,220		$ 869,138	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 NILES NURSING & REHABILITATION **#** 0050088 **Report Period Beginning:** 1/1/2011 **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	$ 3,731	$ 535,647	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	4,525,273	4,849,170	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	33,247	33,247	6
7	Other Prepaid Expenses		2,553,309	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,562,251	$ 7,971,373	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	924,973	924,973	15
16	Equipment, at Historical Cost	275,355	275,355	16
17	Accumulated Depreciation (book methods)	(120,308)	(120,308)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,080,020	$ 1,080,020	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,642,271	$ 9,051,393	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,855,534	$ 1,744,618	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	611,721	611,718	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	Working Capital Note	2,722,000	2,722,000	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,189,255	$ 5,078,336	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)**	$ 5,189,255	$ 5,078,336	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 453,016	$ 3,973,057	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,642,271	$ 9,051,393	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number NILES NURSING & REHABILITATION # 0050088 Report Period Beginning: 1/1/2011 Ending: 12/31/11

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 11,554	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 11,554	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	540,307	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock	(98,845)	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)**	$ 441,462	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)**	$ 453,016	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number NILES NURSING & REHABILITATION # 0050088 Report Period Beginning: 1/1/2011 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	$ 14,689,192	1
2	Discounts and Allowances for all Levels	(763,367)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 13,925,825	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,232,885	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,232,885	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	199,975	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,615	19
20	Radiology and X-Ray	2,287	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 213,877	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	50	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 50	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING	4,072	28
28a	MISCELLANEOUS	15,398	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 19,470	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 15,392,107	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,159,915	31
32	Health Care	6,351,626	32
33	General Administration	2,244,806	33
	B. Capital Expense		
34	Ownership	3,722,793	34
	C. Ancillary Expense		
35	Special Cost Centers	206,220	35
36	Provider Participation Fee	166,440	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 14,851,800	40
41	**Income before Income Taxes (line 30 minus line 40)****	540,307	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 540,307	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 NILES NURSING & REHABILITATION # 0050088 Report Period Beginning: 1/1/2011 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	1,729	2,009	$ 92,318	$ 45.95	1
2	Assistant Director of Nursing					2
3	Registered Nurses	52,151	57,314	1,748,969	30.52	3
4	Licensed Practical Nurses	28,430	30,847	753,898	24.44	4
5	CNAs & Orderlies	144,760	160,372	2,036,700	12.70	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	16,366	18,285	269,946	14.76	9
10	Activity Assistants					10
11	Social Service Workers	8,986	9,610	174,550	18.16	11
12	Dietician	33,497	36,490	477,314	13.08	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	5,110	5,813	84,343	14.51	17
18	Housekeepers	26,170	29,585	335,427	11.34	18
19	Laundry	9,129	10,159	119,252	11.74	19
20	Administrator	1,850	1,992	87,045	43.70	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,379	11,356	301,767	26.57	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	4,416	4,040	60,337	14.93	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	341,973	377,872	$ 6,541,866 *	$ 17.31	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	429	$ 15,000	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	500	25,000	10-3	38
39	Pharmacist Consultant	426	21,277	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	416	14,577	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,771	$ 75,854		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 NILES NURSING & REHABILITATION # 0050088 Report Period Beginning: 1/1/2011 Ending: 12/31/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Michael Perl	Admin	0	$ 87,045
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 87,045

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
Bradley & Associates	Accounting	$ 16,691
Johnson, Goldberg	Accounting	1,500
Infinity Healthcare MGT.	Management Services	354,748
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 372,939

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 133,320
Unemployment Compensation Insurance	
FICA Taxes	513,183
Employee Health Insurance	271,893
Employee Meals	29,505
Illinois Municipal Retirement Fund (IMRF)*	
Uniforms	5,078
SUTA	78,369
FUTA	12,119
Pension	47,235
Life Insurance	8,749
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,099,451

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	$ 1,990
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Cook County	168
Secretary of State	1,075
State Fire Marshall	515
Village of Niles	4,887
Other Fees & License	4,997
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,632

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	29,892
Seminar Expense	1,158
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 31,050

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number NILES NURSING & REHABILITATION # 0050088 Report Period Beginning: 1/1/2011 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 NILES NURSING & REHABILITATION **#** 0050088 **Report Period Beginning:** 1/1/2011 **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. **N/A**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **85,102** Line **10**

(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. $ **166,440**
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? **YES**
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. $ **0**

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

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

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