FOR BHF USE

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2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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

I. IDPH License ID Number: 0048215

Facility Name: Belhaven Nursing & Rehab Ctr

Address: 11401 S Oakley Ave (Number) Chicago (City) 60643 (Zip Code)

County: Cook

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

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Alan Sorscher **Telephone Number:** 708-449-1900
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 01/01/2014 to 12/31/2014 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) Alan Sorscher
(Title) CFO

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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

Facility Name & ID Number Belhaven Nursing & Rehab Ctr # 0048215 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	221	Skilled (SNF)	221	80,665	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	221	TOTALS	221	80,665	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	55,918	4,598	7,162	67,678	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	55,918	4,598	7,162	67,678	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.90%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [x]

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

I. On what date did you start providing long term care at this location?
Date started 07/01/2006

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 07/01/2006 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 221 and days of care provided 5,328

Medicare Intermediary National Governmentr Services

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: 01/01/2014 Fiscal Year: 12/31/2014

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

Facility Name & ID Number Belhaven Nursing & Rehab Ctr # 0048215 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	326,519		10,642	337,161		337,161	2,791	339,952			1
2	Food Purchase		415,585		415,585		415,585		415,585			2
3	Housekeeping	312,945	47,881		360,826		360,826		360,826			3
4	Laundry	138,019	32,671		170,690		170,690		170,690			4
5	Heat and Other Utilities			354,983	354,983		354,983	1,110	356,093			5
6	Maintenance	101,085	52,676	94,232	247,993		247,993	2,430	250,423			6
7	Other (specify):*											7
8	TOTAL General Services	878,568	548,813	459,857	1,887,238		1,887,238	6,331	1,893,569			8
	B. Health Care and Programs											
9	Medical Director			23,825	23,825		23,825		23,825			9
10	Nursing and Medical Records	3,991,330	576,911	35,544	4,603,785		4,603,785	34,061	4,637,846			10
10a	Therapy			700,121	700,121		700,121		700,121			10a
11	Activities	123,663	24,019		147,682		147,682		147,682			11
12	Social Services	93,407		4,557	97,964		97,964		97,964			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* rx cpnsultant			18,294	18,294		18,294		18,294			15
16	TOTAL Health Care and Programs	4,208,400	600,930	782,341	5,591,671		5,591,671	34,061	5,625,732			16
	C. General Administration											
17	Administrative	118,038			118,038		118,038		118,038			17
18	Directors Fees											18
19	Professional Services			529,146	529,146		529,146	(309,644)	219,502			19
20	Dues, Fees, Subscriptions & Promotions			10,809	10,809		10,809		10,809			20
21	Clerical & General Office Expenses	178,255	91,033	426,537	695,825		695,825	135,987	831,812			21
22	Employee Benefits & Payroll Taxes			938,225	938,225		938,225	34,736	972,961			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,333	4,333		4,333	204	4,537			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			881,802	881,802		881,802	1,108	882,910			26
27	Other (specify):*											27
28	TOTAL General Administration	296,293	91,033	2,790,852	3,178,178		3,178,178	(137,609)	3,040,569			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,383,261	1,240,776	4,033,050	10,657,087		10,657,087	(97,217)	10,559,870			29

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

Facility Name & ID Number Belhaven Nursing & Rehab Ctr #0048215 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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			229,131	229,131		229,131	(17,562)	211,569			30
31	Amortization of Pre-Op. & Org.			307,019	307,019		307,019		307,019			31
32	Interest			1,245,853	1,245,853		1,245,853	(55,065)	1,190,788			32
33	Real Estate Taxes			475,526	475,526		475,526		475,526			33
34	Rent-Facility & Grounds			1,680,000	1,680,000		1,680,000	(1,662,581)	17,419			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* replacement tax			4,985	4,985		4,985		4,985			36
37	TOTAL Ownership			3,942,514	3,942,514		3,942,514	(1,735,208)	2,207,306			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		250,497	45,604	296,101		296,101		296,101			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			503,056	503,056		503,056		503,056			42
43	Other (specify):*			1,076,484	1,076,484		1,076,484	(1,076,484)				43
44	TOTAL Special Cost Centers		250,497	1,625,144	1,875,641		1,875,641	(1,076,484)	799,157			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,383,261	1,491,273	9,600,708	16,475,242		16,475,242	(2,908,909)	13,566,333			45

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

Facility Name & ID Number Belhaven Nursing & Rehab Ctr # 0048215 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	(17,562)	30		9
10	Interest and Other Investment Income	(55,065)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		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	(1,076,484)	43		24
25	Fund Raising, Advertising and Promotional	(6,316)	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	(1,690,520)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (2,845,947)		$	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)	(62,962)	various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (62,962)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (2,908,909)		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

Belhaven Nursing & Rehab Ctr

ID# 0048215

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	misc income	$ (10,520)	21	1
2	rent	(1,680,000)	34	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
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39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(1,690,520)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Belhaven Nursing & Rehab Ctr # 0048215 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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	2,791	0	0	0	0	0	0	0	0	0	2,791	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	1,110	0	0	0	0	0	0	0	0	0	1,110	5
6	Maintenance	0	2,430	0	0	0	0	0	0	0	0	0	2,430	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	6,331	0	0	0	0	0	0	0	0	0	6,331	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	34,061	0	0	0	0	0	0	0	0	0	34,061	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	34,061	0	0	0	0	0	0	0	0	0	34,061	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	(309,644)	0	0	0	0	0	0	0	0	0	(309,644)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(16,836)	152,823	0	0	0	0	0	0	0	0	0	135,987	21
22	Employee Benefits & Payroll Taxes	0	34,736	0	0	0	0	0	0	0	0	0	34,736	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	204	0	0	0	0	0	0	0	0	0	204	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	1,108	0	0	0	0	0	0	0	0	0	1,108	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(16,836)	(120,773)	0	0	0	0	0	0	0	0	0	(137,609)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(16,836)	(80,381)	0	0	0	0	0	0	0	0	0	(97,217)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Belhaven Nursing & Rehab Ctr # 0048215 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(17,562)	0	0	0	0	0	0	0	0	0	0	(17,562)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(55,065)	0	0	0	0	0	0	0	0	0	0	(55,065)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(1,680,000)	17,419	0	0	0	0	0	0	0	0	0	(1,662,581)	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	(1,752,627)	17,419	0	0	0	0	0	0	0	0	0	(1,735,208)	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):*	(1,076,484)	0	0	0	0	0	0	0	0	0	0	(1,076,484)	43
44	TOTAL Special Cost Centers	(1,076,484)	0	0	0	0	0	0	0	0	0	0	(1,076,484)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(2,845,947)	(62,962)	0	0	0	0	0	0	0	0	0	(2,908,909)	45

Facility Name & ID Number Belhaven Nursing & Rehab Ctr # 0048215 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Michael Blisko	35%			Infinity Healthcare	Hillside, IL	Mgmt Co.
Moishe Gubin	35%					
A & F realty	30%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	dietary wages	$ 10,642	Infinity Healthcare Management of Illinois, LLC		$ 13,433	$ 2,791	1
2	V	6	maint wages		Infinity Healthcare Management of Illinois, LLC		2,039	2,039	2
3	V	10	nursing wages	29,044	Infinity Healthcare Management of Illinois, LLC		63,105	34,061	3
4	V	21	admin wages		Infinity Healthcare Management of Illinois, LLC		208,151	208,151	4
5	V	5	utilities		Infinity Healthcare Management of Illinois, LLC		1,110	1,110	5
6	V	6	maintenance		Infinity Healthcare Management of Illinois, LLC		391	391	6
7	V	19	professional fees	316,672	Infinity Healthcare Management of Illinois, LLC		7,028	(309,644)	7
8	V	21	office expenses	67,811	Infinity Healthcare Management of Illinois, LLC		12,483	(55,328)	8
9	V	22	employee benefits	2,285	Infinity Healthcare Management of Illinois, LLC		37,021	34,736	9
10	V	24	auto/travel	573	Infinity Healthcare Management of Illinois, LLC		777	204	10
11	V	26	insurance		Infinity Healthcare Management of Illinois, LLC		1,108	1,108	11
12	V	34	rent		Infinity Healthcare Management of Illinois, LLC		17,419	17,419	12
13	V	32	interest		Infinity Healthcare Management of Illinois, LLC				13
14	Total			$ 427,027			$ 364,065	$ * (62,962)	14

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

Facility Name & ID Number Belhaven Nursing & Rehab Ctr # 0048215 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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
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20								20
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22								22
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25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Belhaven Nursing & Rehab Ctr # 0048215 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Belhaven Nursing & Rehab Ctr # 0048215 Report Period Beginning: 01/01/2014 Ending: 2/31/2014

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

Facility Name & ID Number Belhaven Nursing & Rehab Ctr # 0048215 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	midwest bank		x	mortgage	int only	05/21/2014	$ 18,880,000	$ 18,880,000	4/1/17	3.4170	$ 1,062,174	1
2												2
3												3
4												4
5												5
	Working Capital											
6	capital one		x	working capital	n/a	8/31/14	15,000,000	1,106,963	08/31/2018	various	94,634	6
7	infinity funding			working capital	n/a	n/a	743,000	743,000	n/a	various	89,045	7
8												8
9	TOTAL Facility Related						$ 34,623,000	$ 20,729,963			$ 1,245,853	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 34,623,000	$ 20,729,963			$ 1,245,853	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.)**

Facility Name & ID Number Belhaven Nursing & Rehab Ctr # 0048215 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 149,543	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.)		$ 413,096	2
3. Under or (over) accrual (line 2 minus line 1).		$ 263,553	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 211,973	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.		$ 475,526	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	377,411	8
	2010	379,078	9
	2011	377,566	10
	2012	430,741	11
	2013	413,096	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Belhaven Nursing & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0048215

CONTACT PERSON REGARDING THIS REPORT Alan Sorscher

TELEPHONE 708-449-1900 FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	25-19-110-040-0000	nursing home	$ 413,095.74	$ 413,095.74
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 413,095.74	$ 413,095.74

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

Facility Name & ID Number Belhaven Nursing & Rehab Ctr # 0048215 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 78,370 B. General Construction Type: Exterior brick Frame steel Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

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

1. Total Amount Incurred: 4,605,292 2. Number of Years Over Which it is Being Amortized: 15

3. Current Period Amortization: 307,319 4. Dates Incurred: prior to 04/11/2006

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			4/11/2006	$ 100,000	1
2					2
3	TOTALS			$ 100,000	3

Facility Name & ID Number Belhaven Nursing & Rehab Ctr # 0048215 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	221		2006		$ 6,511,000	$ 151,752	39	$ 166,949	$ 15,197	$ 1,198,715	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Wanderguard Security Camera			7/25/2006	37,000	949	39	949		8,539	9
10	Improvements - Paint & Painting Supplies			10/1/2006	600	15	39	15		137	10
11	2nd Floor Remodeling - Cove Base for Rooms			11/1/2006	1,408	36	39	36		325	11
12	2nd Floor Remodeling - Wall Protection & Corner Guards			11/1/2006	2,372	61	39	61		548	12
13	2nd Floor Remodeling - Floor & Tile			11/1/2006	5,418	139	39	139		1,251	13
14	2nd Floor Remodeling - Paint & Painting Supplies			11/1/2006	14,919	383	39	383		3,444	14
15	2nd Floor Remodeling - Cove Base, Vertical Dividers, Wood Drift			11/1/2006	2,275	58	39	58		524	15
16											16
17	Fast Signs			1/9/2007	3,352	86	39	86		688	17
18	Draperies, Light Fixtures, Cascades			1/23/2007	19,454	499	39	499		3,991	18
19	Painting & Supplies			2/1/2007	1,500	38	39	38		306	19
20	Water Pump & Boiler Tank			2/26/2007	7,156	183	39	183		1,466	20
21	Paint & Supplies			3/1/2007	2,657	68	39	68		545	21
22	Paint & Supplies			4/1/2007	5,520	142	39	142		1,134	22
23	Wall Paper, Wall Protection			5/1/2007	7,306	187	39	187		1,498	23
24	Paint & Supplies			5/1/2007	4,746	122	39	122		974	24
25	Heating & Cooling Pump			5/7/2007	4,214	108	39	108		864	25
26	Paint & Supplies			6/1/2007	8,833	226	39	226		1,810	26
27	Air Handler			6/4/2007	6,160	158	39	158		1,264	27
28	Wall Protection & Corner Guards			6/27/2007	7,957	204	39	204		1,632	28
29	Paint & Supplies			7/1/2007	4,744	122	39	122		974	29
30	Paint & Supplies			8/1/2007	5,247	135	39	135		1,078	30
31	Electric Work			8/2/2007	5,438	139	39	139		1,114	31
32	A/C			8/8/2007	2,534	65	39	65		520	32
33	Paint & Supplies			9/1/2007	4,393	113	39	113		902	33
34	Paint & Supplies			10/1/2007	6,499	167	39	167		1,334	34
35	Lights, Wall Protection, Draperies			10/9/2007	27,168	697	39	697		5,574	35
36	Shower Valve			11/1/2007	3,650	94	39	94		750	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Belhaven Nursing & Rehab Ctr # 0048215 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	Paint & Supplies	11/1/2007	$ 3,076	$ 79	39	$ 79	$	$ 631	37
38	Electric Work	11/9/2007	10,269	263	39	263		2,106	38
39	Wall Covering	11/28/2007	3,161	81	39	81		648	39
40	Hydraulic Valve	11/28/2007	4,207	108	39	108		863	40
41	Paint & Supplies	12/1/2007	2,065	53	39	53		424	41
42									42
43	Kickplates/Wallcoverings	1/11/2008	3,130	80	39	80		561	43
44	Kickplates/Wallcoverings	4/24/2008	4,179	107	39	107		750	44
45	Valve Replacement	5/13/2008	3,650	94	39	94		656	45
46	Cooling Tower	6/20/2008	4,093	105	39	105		735	46
47	Water Heater parts replacement	12/5/2008	1,516	39	39	39		273	47
48	Water Heater parts replacement	12/24/2008	969	25	39	25		174	48
49	Dining Room	1/15/2008	3,600	92	39	92		645	49
50	Paint/Remodel	2/5/2008	2,300	59	39	59		413	50
51	2nd Floor Paint/Remodel	4/4/2008	3,000	77	39	77		539	51
52	3rd Floor Paint/Remodel	5/16/2008	3,500	90	39	90		629	52
53	Paint/Remodel	5/22/2008	1,500	38	39	38		268	53
54	Remodel - Cabinets/Light Fixtures	9/12/2008	600	15	39	15		107	54
55	Remodel - Cabinets/Light Fixtures	9/12/2008	1,400	36	39	36		252	55
56	Remodel Supplies	10/14/2008	600	15	39	15		107	56
57	Remodel Supplies	1/15/2008	252	6	39	6		44	57
58	Remodel Supplies	2/5/2008	269	7	39	7		49	58
59	Remodel Supplies	4/14/2008	406	10	39	10		72	59
60	Remodel Supplies	4/21/2008	663	17	39	17		119	60
61	Remodel Supplies	4/23/2008	489	13	39	13		89	61
62	Remodel Supplies	5/16/2008	326	8	39	8		57	62
63	Remodel Supplies	5/22/2008	465	12	39	12		84	63
64	Remodel Supplies	9/11/2008	1,106	28	39	28		197	64
65	Remodel Supplies	9/2/2008	1,470	38	39	38		265	65
66	Remodel Supplies	9/12/2008	606	16	39	16		110	66
67	Elevator	4/10/2008	3,006	77	39	77		539	67
68	Elevator	7/21/2008	5,538	142	39	142		994	68
69	Elevator	12/26/2008	4,407	113	39	113		791	69
70	TOTAL (lines 4 thru 69)		$ 6,789,338	$ 158,889		$ 174,086	$ 15,197	$ 1,256,092	70

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

Facility Name & ID Number Belhaven Nursing & Rehab Ctr # 0048215 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,789,338	$ 158,889		$ 174,086	$ 15,197	$ 1,256,092	1
2	Sprinkler Repairs	7/31/2008	537	14	39	14		97	2
3	Sprinkler Repairs	8/28/2008	653	17	39	17		118	3
4	Sprinkler Repairs	8/29/2008	1,510	39	39	39		272	4
5	Sprinkler Repairs	8/31/2008	1,980	51	39	51		356	5
6	Sprinkler Repairs	8/31/2008	1,156	30	39	30		209	6
7									7
8	Floor Tile	8/19/2009	23,845	611	39	611		3,667	8
9	Remove and Replace Floor Tile	7/8/2009	3,000	77	39	77		462	9
10	New Tile in Shower Room	9/28/2009	3,000	77	39	77		462	10
11	Install Sheetrock in Shower Room	11/18/2009	3,000	77	39	77		462	11
12	Install wood paneling, handrails, corner guards	12/30/2009	3,000	77	39	77		462	12
13	Install Doors, Frames, and Glass	10/20/2009	14,489	372	39	372		2,231	13
14	New Doors	4/16/2009	910	23	39	23		139	14
15	New Doors	6/3/2009	1,134	29	39	29		174	15
16	Repair Sinkhole, Repair Pavement, Reseal & Restripe Park.	4/3/2009	9,625	247	39	247		1,481	16
17	New Faucets and Drains	10/7/2009	2,235	57	39	57		343	17
18	New Faucets and Drains	12/28/2009	1,290	33	39	33		198	18
19	New Faucets and Drains	12/21/2009	1,725	44	39	44		265	19
20	New Faucets and Drains	12/21/2009	1,725	44	39	44		265	20
21	New Roofing	9/14/2009	68,755	1,763	39	1,763		10,578	21
22	New Roofing	10/16/2009	1,950	50	39	50		300	22
23	Install and Paint Over Water Lines	6/19/2009	785	20	39	20		120	23
24	Install and Paint Over Water Lines	5/21/2009	1,700	44	39	44		263	24
25	Removal of Old Dooring & Installation of Dura Glides	12/17/2009	12,315	316	39	316		1,895	25
26	Wall Coverings. Wall Tiles, Table Lamps, Ceiling Pendants	12/29/2009	25,004	641	39	641		3,846	26
27									27
28	Drywall & Construction Supplies	10/13/2010	1,302	33	39	33		166	28
29	Shower Remodeling, 2nd Floor	1/20/2010	3,000	77	39	77		385	29
30	Shower Remodeling, 2nd Floor - Fixing Cracked Tiles	2/3/2010	3,000	77	39	77		385	30
31	Replacement Ceiling Tiles	12/7/2010	2,750	71	39	71		354	31
32	Replacement Ceiling Tiles, Paint, Fixing Duct	12/16/2010	2,410	62	39	62		310	32
33	Cleaners, Paints, Door Hinges, Flooring	12/16/2010	1,216	31	39	31		155	33
34	TOTAL (lines 1 thru 33)		$ 6,988,339	$ 163,993		$ 179,190	$ 15,197	$ 1,286,512	34

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

Facility Name & ID Number Belhaven Nursing & Rehab Ctr # 0048215 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 6,988,339	$ 163,993		$ 179,190	$ 15,197	$ 1,286,512	1
2	Hardware for Doors/Flooring	12/17/2010	1,746	45	39	45		225	2
3	Elevator	8/5/2010	153,000	3,923	39	3,923		23,382	3
4	Hinges, Paint, Glass, and Stainless Steel for Basement	6/24/2010	6,115	157	39	157		785	4
5	Metal Doors Setup	12/9/2010	6,175	158	39	158		791	5
6	Door Locks	12/14/2010	475	12	39	12		60	6
7					39				7
8	Concrete Work	9/27/2011	11,000	282	39	282		2,397	8
9	Concrete & Asphalt Work	9/27/2011	6,750	173	39	173		692	9
10	Asphalt Work	11/12/2011	1,575	40	39	40		160	10
11	Fire Alarm System Devices	5/27/2011	8,506	218	39	218		872	11
12	HUD Inspection Preparation	1/5/2011	5,325	137	39	137		548	12
13	Sprinkler Addition in Elevator Pit	9/27/2011	2,575	66	39	66		264	13
14	New Hydronic Heater	1/24/2011	5,470	140	39	140		560	14
15	Chiller Compressor Replacement	4/20/2011	10,300	264	39	264		1,056	15
16	Chiller & Cooling Tower Cleaning	5/4/2011	7,950	204	39	204		816	16
17	New Cooling Tower Fan Motor Pulley & Blower Belts	7/6/2011	4,318	111	39	111		444	17
18	Kitchen Air Handler	8/2/2011	1,245	32	39	32		128	18
19	Sewer Dig Up & Repair	6/9/2011	10,500	269	39	269		1,076	19
20	Replaced Broken Pipe& Filled Holes w/ Concrete	7/6/2011	5,200	133	39	133		532	20
21	Remodel Offices- Ceiling Tiles, Flooring, Lighting, Paint	11/30/2011	8,486	218	39	218		872	21
22	Remodel Nurses Stations- Lighting, Coffered Ceiling, Floor				39				22
23	Tile, New Work Stations, Sink, Paint	11/30/2011	107,949	2,768	39	2,768		11,072	23
24	Remodel Corridors- Lighting, Floor Tile, Ceiling Tile,				39				24
25	Wallcovering, Handrail, Corner Gauards, Paint Doors	11/30/2011	315,993	8,102	39	8,102		32,408	25
26	Remodel Dining Rooms- Lighting, Drywall, Floor Tile, Ceiling				39				26
27	Tile, Paint, Wallcoverings, Corner Gaurds, Roller Shades	11/30/2011	112,227	2,878	39	2,878		11,512	27
28	Remodel PT Room- Lighting, Tile, Paint, Cabinets, Countertops	11/30/2011	36,356	932	39	932		3,728	28
29	Elevators- New Flooring, Wall Panels, Wall Base, Ceiling	11/30/2011	18,834	483	39	483		1,932	29
30	Specialty Consultation re: Safety Code Surveys	6/20/2011	2,905	74	39	74		296	30
31	Develop Fires Saftey Evaluation System	8/25/2011	5,278	135	39	135		540	31
32	Ceiling Panel	1/3/2011	547	14	39	14		56	32
33	Smoke Damper	2/1/2010	3,900	100	39	100		400	33
34	TOTAL (lines 1 thru 33)		$ 7,849,039	$ 186,061		$ 201,258	$ 15,197	$ 1,384,116	34

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

Facility Name & ID Number Belhaven Nursing & Rehab Ctr # 0048215 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 7,849,039	$ 186,061		$ 201,258	$ 15,197	$ 1,384,116	1
2	Insulated Unit	1/12/2011	760	19	39	19		77	2
3	Insulated Unit	1/25/2011	705	18	39	18		72	3
4	Building Light	11/11/2011	710	18	39	18		72	4
5	Metal Door	1/3/2011	6,560	168	39	168		672	5
6					39				6
7	Replaced/Reprogrammed Pull Station	1/9/2012	2,834	73	39	73		219	7
8	Sprinkler Work	1/18/2012	4,925	126	39	126		378	8
9	Installed Ductwork necessary for Oxygen Rooms	1/20/2012	4,645	119	39	119		357	9
10	Metal Doors	1/24/2012	1,215	31	39	31		93	10
11	Sales tax on Metal Doors	1/24/2012	85	2	39	2		6	11
12	Repair Roof	2/20/2012	3,600	92	39	92		276	12
13	Install 28 Smoke Detectors & Fire Alarm System	3/21/2012	9,102	233	39	233		699	13
14	Credit for Expense Claimed in PY	3/22/2012	(110,243)	(2,827)	39	(2,827)		(8,481)	14
15	Replace Cast Iron Pipe	4/4/2012	1,400	36	39	36		108	15
16	Mechanical Rooms Repairs	6/18/2012	1,100	28	39	28		84	16
17	Basement Bathroom Ventilation	8/21/2012	4,000	103	39	103		309	17
18	Repair Heating	8/22/2012	3,838	98	39	98		294	18
19	Lever lockset	8/29/2012	811	21	39	21		63	19
20	Lever Lockset	8/29/2012	2,572	66	39	66		198	20
21	Metal Doors	8/30/2012	4,450	114	39	114		342	21
22	Repair Heating	9/10/2012	1,970	51	39	51		153	22
23	New Flooring and walls throughout entire facility	11/1/2012	47,836	1,227	39	1,227		3,681	23
24	Misc Repairs to piping in kitchen	11/2/2012	3,100	79	39	79		237	24
25	Install Precision Lamps on first floor nurses station	11/2/2012	3,551	91	39	91		273	25
26	New Flooring and walls throughout entire facility	12/14/2012	50,586	1,297	39	1,297		3,891	26
27	New Flooring and walls throughout entire facility	12/14/2012	60,320	1,547	39	1,547		4,641	27
28									28
29	Items deleted in FY10 and before capital rate reconciliation		127,534	3,375	39	3,375		12,067	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,087,005	$ 192,266		$ 207,463	$ 15,197	$ 1,404,897	34

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

Facility Name & ID Number Belhaven Nursing & Rehab Ctr # 0048215 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 8,087,005	$ 192,266		$ 207,463	$ 15,197	$ 1,404,897	1
2	Direct Supply	2013	4,260	109	39	109		164	2
3	Five Star - Parking Lot	2013	8,750	224	39	224		336	3
4	Fox Valley Fire & Safety	2013	13,058	335	39	335		502	4
5	Econocare	2013	51,560	1,322	39	1,322		1,983	5
6	Alternative Energy	2013	4,708	121	39	121		181	6
7	Adig Construction	2013	3,975	102	39	102		153	7
8	Eidco Credit	2013	(50,586)	(1,297)	39	(1,297)		(1,946)	8
9	Protective Fire 7 Safety	2013	6,299	162	39	162		243	9
10	Life Safety Resource	2013	2,819	72	39	72		108	10
11	Superior Construction	2013	25,613	657	39	657		986	11
12	other	2013	53,560	1,373	39	1,373		2,060	12
13									13
14	DIRECT SUPPLY	2014	2,015	52	39	22	(30)	22	14
15	DIRECT SUPPLY	2014	3,020	77	39	6	(71)	6	15
16	FIVE STAR - ADDITIONAL WORK DONE BACK IN OCTOBE	2014	850	22	39	22		22	16
17	Cover base/flooring	2014	3,679	94	39	47	(47)	47	17
18	Cover base/flooring	2014	3,001	77	39	32	(45)	32	18
19	Security Camera system	2014	5,722	147	39	37	(110)	37	19
20	Beauty Shop	2014	4,400	113	39	47	(66)	47	20
21	Chller	2014	6,995	179	39	104	(75)	104	21
22	Booster pump	2014	2,498	64	39	27	(37)	27	22
23	Boiler & heater	2014	2,057	53	39	17	(36)	17	23
24	Floors in beauty shop	2014	1,718	44	39	11	(33)	11	24
25	TNS INC	2014	2,844	73	39	73		73	25
26	VALLEY FIRE PROTECTION SERVICES, LLC	2014	2,214	57	39	5	(52)	5	26
27	Washer	2014	9,900	254	39	42	(212)	42	27
28	Life Safety Resource site vist prep	2014	4,855	124	39	104	(20)	104	28
29	Cove base/flooring	2014	3,273	84	39	77	(7)	77	29
30	Signage	2014	6,670	171	39	171		176	30
31	Carpet and flooring	2014	3,476	89	39	82	(7)	82	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,280,205	$ 197,220		$ 211,569	$ 14,349	$ 1,410,598	34

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

Facility Name & ID Number Belhaven Nursing & Rehab Ctr # 0048215 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	$ 882,600	$ (10,725)	$	$ 10,725		$ 882,600	71
72	Current Year Purchases	42,636	42,636		(42,636)		42,636	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 925,236	$ 31,911	$	$ (31,911)		$ 925,236	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)	$ 9,305,441	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 229,131	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 211,569	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (17,562)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,335,834	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Belhaven Nursing & Rehab Ctr # 0048215 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2015	$
13.	/2016	$
14.	/2017	$

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

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

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Belhaven Nursing & Rehab Ctr # 0048215 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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.

Facility Name & ID Number Belhaven Nursing & Rehab Ctr # 0048215 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-3	hrs	$		$ 177,448	$		$ 177,448	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs			63,218			63,218	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs			459,455			459,455	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				168,332		168,332	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): xray lab ambulance	39-2					45,604		45,604	12
13	Other (specify):									13
14	TOTAL			$		$ 700,121	$ 213,936		$ 914,057	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.

STATE OF ILLINOIS

Facility Name & ID Number Belhaven Nursing & Rehab Ctr # 0048215 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2014 (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	$ (489,635)	$ (489,535)	1
2	Cash-Patient Deposits	(30,837)	(30,837)	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	5,647,910	5,647,910	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	778,940	778,940	6
7	Other Prepaid Expenses	477,526	477,526	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 6,383,904	$ 6,384,004	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		100,000	13
14	Buildings, at Historical Cost		5,500,000	14
15	Leasehold Improvements, at Historical Cost	1,773,211	1,773,211	15
16	Equipment, at Historical Cost	775,236	925,236	16
17	Accumulated Depreciation (book methods)	(987,965)	(2,336,680)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		4,605,292	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(2,609,665)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): escrow		21,000	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,560,482	$ 7,978,394	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,944,386	$ 14,362,398	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,450,241	$ 1,885,229	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	626,767	626,767	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	settlement reserve	70,080	70,080	36
37	working capital	1,849,963	1,849,963	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,997,051	$ 4,432,039	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		18,880,000	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)**	$	$ 18,880,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,997,051	$ 23,312,039	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,947,335	$ (8,949,641)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,944,386	$ 14,362,398	48

*(See instructions.)

Facility Name & ID Number Belhaven Nursing & Rehab Ctr # 0048215 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,309,870	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,309,870	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(149,424)	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) **related party property co net income**	786,889	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 637,465	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,947,335	24 *

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

Facility Name & ID Number Belhaven Nursing & Rehab Ctr # 0048215 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 14,312,754	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 14,312,754	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	267,487	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 267,487	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		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		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	55,057	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 55,057	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	rental & misc income	1,690,520	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,690,520	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 16,325,818	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,887,238	31
32	Health Care	5,591,671	32
33	General Administration	3,178,178	33
	B. Capital Expense		
34	Ownership	3,942,514	34
	C. Ancillary Expense		
35	Special Cost Centers	296,101	35
36	Provider Participation Fee	503,056	36
	D. Other Expenses (specify):		
37	bad debt expense	1,076,484	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 16,475,242	40
41	**Income before Income Taxes (line 30 minus line 40)****	(149,424)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (149,424)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 9,456,326	44
45	Private Pay - Net Inpatient Revenue	1,594,047	45
46	Medicare - Net Inpatient Revenue	2,637,675	46
47	Other-(specify)	624,706	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 14,312,754	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 Belhaven Nursing & Rehab Ctr # 0048215 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	1,208	1,263	$ 61,024	$ 48.32	1
2	Assistant Director of Nursing	1,664	1,786	63,823	35.74	2
3	Registered Nurses	11,995	12,635	374,257	29.62	3
4	Licensed Practical Nurses	61,368	67,933	1,848,079	27.20	4
5	CNAs & Orderlies	122,839	133,139	1,633,726	12.27	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	9,948	10,793	123,713	11.46	9
10	Activity Assistants					10
11	Social Service Workers	3,988	4,253	93,407	21.96	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	26,563	28,272	326,073	11.53	15
16	Dishwashers					16
17	Maintenance Workers	4,553	4,970	101,085	20.34	17
18	Housekeepers	25,173	27,849	312,946	11.24	18
19	Laundry	9,759	10,805	138,019	12.77	19
20	Administrator	1,944	2,161	118,038	54.62	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,124	9,804	125,292	12.78	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	4,851	5,422	63,779	11.76	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	294,977	321,085	$ 5,383,261 *	$ 16.77	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	213	$ 10,642	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	366	18,294	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	91	4,557	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	670	$ 33,493		49

C. CONTRACT NURSES

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

Facility Name & ID Number Belhaven Nursing & Rehab Ctr # 0048215 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Matthew Macklin			$ 43,907
Caroline Hamilton			18,955
Ayodeji Adegoye			55,176
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 118,038

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
LEWIS BRISBIS BISGAARD & SM	Legal	$ 92,345
POLSINELLI PC	Legal	113
SWANSON, MARTIN & BELL, LL	Legal	15,645
Infinity Healthcare Mgmt	Legal	206
Private Bank Fees	Legal & Professional	67,631
Bradley & Associates	Accounting	9,367
Infinity Healthcare Mgmt	Accounting	1,466
Johnson, Goldburg	Accounting	2,500
Infinity Healthcare Mgmt	Mgmt Fees	315,000
Neal Gerber Eisenberg	Mgmt Fees	9,702
MGKappy Consulting & Redridge	Professional	13,218
MTS Consulting	Professional	1,953
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 529,146

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 166,475
Unemployment Compensation Insurance	214,998
FICA Taxes	419,210
Employee Health Insurance	79,280
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
pension expense	17,760
uniforms	3,746
employee expenses	68,884
benefits	2,608
TOTAL (agree to Schedule V, line 22, col.8)	$ 972,961

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
illinois council	8,276
CLIA	150
sec of state	250
city of chicago	1,350
various	783
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,809

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
mileage	1,259
continuing education	24
auto allowance	3,254
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,537

**See instructions.

Facility Name & ID Number Belhaven Nursing & Rehab Ctr # 0048215 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Belhaven Nursing & Rehab Ctr # 0048215 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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? **yes**
If YES, give association name and amount. **illinois council**

(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?

(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. $ **95,120** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **no**
If YES, give effective date of lease. **n/a**

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **503,056**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **none** Has any meal income been offset against related costs? **n/a** Indicate the amount. $ **n/a**

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

(17) Has an audit been performed by an independent certified public accounting firm? **no**
Firm Name:

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **yes**
Attach invoices and a summary of services for all architect and appraisal fees.