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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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: 708-449-1900 **Fax #** 708-449-1500

HFS ID Number:

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

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/15 to 12/31/15 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) Flora Reznik
(Title) CFO

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Daniel S. Gaafar, Partner
(Firm Name & Address) Bradley Associates, 201 S. Capitol Ave, Suite 700, 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**

Facility Name & ID Number Belhaven Nursing & Rehab Ctr # 0048215 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	57,292	2,074	6,443	65,809	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	57,292	2,074	6,443	65,809	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.58%

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 7/1/2006

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 7/1/2006 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 6,429

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/15 Fiscal Year: 12/31/15

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

Facility Name & ID Number Belhaven Nursing & Rehab Ctr # 0048215 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	355,753		52,628	408,381		408,381	235	408,616			1
2	Food Purchase		350,054		350,054		350,054		350,054			2
3	Housekeeping	337,192	54,784		391,976		391,976		391,976			3
4	Laundry	140,180	47,898		188,078		188,078		188,078			4
5	Heat and Other Utilities			367,731	367,731		367,731	2,611	370,342			5
6	Maintenance	96,791	60,039	96,695	253,525		253,525	1,796	255,321			6
7	Other (specify):*											7
8	**TOTAL General Services**	929,916	512,775	517,054	1,959,745		1,959,745	4,642	1,964,387			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	4,154,825	476,373	33,594	4,664,792		4,664,792	(14,227)	4,650,565			10
10a	Therapy			912,462	912,462		912,462		912,462			10a
11	Activities	141,809	30,496		172,305		172,305		172,305			11
12	Social Services	81,438		4,666	86,104		86,104		86,104			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* RX Consultant			19,188	19,188		19,188		19,188			15
16	**TOTAL Health Care and Programs**	4,378,072	506,869	993,910	5,878,851		5,878,851	(14,227)	5,864,624			16
	C. General Administration											
17	Administrative	95,641			95,641		95,641		95,641			17
18	Directors Fees											18
19	Professional Services			787,607	787,607		787,607	(347,430)	440,177			19
20	Dues, Fees, Subscriptions & Promotions			4,591	4,591		4,591		4,591			20
21	Clerical & General Office Expenses	181,834	68,044	(78,229)	171,649		171,649	145,306	316,955			21
22	Employee Benefits & Payroll Taxes			959,862	959,862		959,862	35,841	995,703			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,586	6,586		6,586	1,867	8,453			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			1,180,784	1,180,784		1,180,784	10,069	1,190,853			26
27	Other (specify):*											27
28	**TOTAL General Administration**	277,475	68,044	2,861,201	3,206,720		3,206,720	(154,347)	3,052,373			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,585,463	1,087,688	4,372,165	11,045,316		11,045,316	(163,932)	10,881,384			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: 01/01/15 Ending: 12/31/15

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			103,321	103,321		103,321	270,284	373,605			30
31	Amortization of Pre-Op. & Org.							168,219	168,219			31
32	Interest			47,925	47,925		47,925	775,362	823,287			32
33	Real Estate Taxes							389,156	389,156			33
34	Rent-Facility & Grounds			1,680,000	1,680,000		1,680,000	(1,673,456)	6,544			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Replacement Tax			3,358	3,358		3,358		3,358			36
37	TOTAL Ownership			1,834,604	1,834,604		1,834,604	(70,435)	1,764,169			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			75	75		75		75			38
39	Ancillary Service Centers		204,945		204,945		204,945		204,945			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			482,552	482,552		482,552		482,552			42
43	Other (specify):* Bad Debt Exp			1,425,000	1,425,000		1,425,000	(1,425,000)				43
44	TOTAL Special Cost Centers		204,945	1,907,627	2,112,572		2,112,572	(1,425,000)	687,572			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,585,463	1,292,633	8,114,396	14,992,492		14,992,492	(1,659,367)	13,333,125			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: 01/01/15 Ending: 12/31/15

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	25,683	30		9
10	Interest and Other Investment Income	(63,997)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(58)	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	(1,525)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,425,000)	43		24
25	Fund Raising, Advertising and Promotional	(10,174)	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	(17,191)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,492,262)		$	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)	(167,105)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (167,105)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,659,367)		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					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS **Page 5A**

Belhaven Nursing & Rehab Ctr

ID# **0048215**

Report Period Beginning: **01/01/15**

Ending: **12/31/15**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Income	$ (17,191)	21	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
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**	(17,191)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Belhaven Nursing & Rehab Ctr # 0048215 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	(58)	293	0	0	0	0	0	0	0	0	0	235	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	2,611	0	0	0	0	0	0	0	0	0	2,611	5
6	Maintenance	0	1,796	0	0	0	0	0	0	0	0	0	1,796	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(58)	4,700	0	0	0	0	0	0	0	0	0	4,642	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	(14,227)	0	0	0	0	0	0	0	0	0	(14,227)	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	(14,227)	0	0	0	0	0	0	0	0	0	(14,227)	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	(378,684)	31,254	0	0	0	0	0	0	0	0	(347,430)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(28,890)	174,029	167	0	0	0	0	0	0	0	0	145,306	21
22	Employee Benefits & Payroll Taxes	0	35,841	0	0	0	0	0	0	0	0	0	35,841	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,867	0	0	0	0	0	0	0	0	0	1,867	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	3,080	6,989	0	0	0	0	0	0	0	0	10,069	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(28,890)	(163,867)	38,410	0	0	0	0	0	0	0	0	(154,347)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(28,948)	(173,394)	38,410	0	0	0	0	0	0	0	0	(163,932)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Belhaven Nursing & Rehab Ctr **#** 0048215 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	25,683	0	244,601	0	0	0	0	0	0	0	0	270,284	30
31	Amortization of Pre-Op. & Org.	0	0	168,219	0	0	0	0	0	0	0	0	168,219	31
32	Interest	(63,997)	0	839,359	0	0	0	0	0	0	0	0	775,362	32
33	Real Estate Taxes	0	4,529	384,627	0	0	0	0	0	0	0	0	389,156	33
34	Rent-Facility & Grounds	0	6,544	(1,680,000)	0	0	0	0	0	0	0	0	(1,673,456)	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	(38,314)	11,073	(43,194)	0	0	0	0	0	0	0	0	(70,435)	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):*	(1,425,000)	0	0	0	0	0	0	0	0	0	0	(1,425,000)	43
44	TOTAL Special Cost Centers	(1,425,000)	0	0	0	0	0	0	0	0	0	0	(1,425,000)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,492,262)	(162,321)	(4,784)	0	0	0	0	0	0	0	0	(1,659,367)	45

Facility Name & ID Number Belhaven Nursing & Rehab Ctr # 0048215 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	Ambassador Nursing & Rehab Center	Chicago	Infinity Healthcare	Hillside	Consulting Co.
Moishe Gubin	35	City View Multicare Center	Cicero	Belhaven Realty, LLC		Realty Co
A & F realty	30	Continental Nursing & Rehab Center	Chicago			
		Forest View Rehab & Nursing Center	Itasca			
		Lakeview Nursing & Rehab Center	Chicago			
		Midway Neurological & Rehab Center	Bridgeview			

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	$ 10,642	Infinity Healthcare Management		$ 10,935	$ 293	1
2	V	10	Nursing Wages	65,970	Infinity Healthcare Management		51,743	(14,227)	2
3	V	21	Office Wages		Infinity Healthcare Management		213,418	213,418	3
4	V	5	Utilities		Infinity Healthcare Management		2,611	2,611	4
5	V	6	Maintenance		Infinity Healthcare Management		1,796	1,796	5
6	V	19	Professional Services	379,808	Infinity Healthcare Management		1,124	(378,684)	6
7	V	21	Office Expense	57,864	Infinity Healthcare Management		18,475	(39,389)	7
8	V	22	Employee Benefit	3,521	Infinity Healthcare Management		39,362	35,841	8
9	V	24	Auto/Travel Expense	1,009	Infinity Healthcare Management		2,876	1,867	9
10	V	26	Insurance		Infinity Healthcare Management		3,080	3,080	10
11	V	33	Property Tax		Infinity Healthcare Management		4,529	4,529	11
12	V	34	Rent		Infinity Healthcare Management		6,544	6,544	12
13	V								13
14	Total			$ 518,814			$ 356,493	$ * (162,321)	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: 01/01/15 Ending: 12/31/15

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	19	Professional Fees	$	Belhaven Realty , LLC		$ 31,254	$ 31,254	15
16	V	21	Office Expense		Belhaven Realty , LLC		167	167	16
17	V	26	Insurance		Belhaven Realty , LLC		6,989	6,989	17
18	V	30	Depreciation		Belhaven Realty , LLC		244,601	244,601	18
19	V	31	Amortization		Belhaven Realty , LLC		168,219	168,219	19
20	V	32	Interest		Belhaven Realty , LLC		839,359	839,359	20
21	V	33	Property Taxes		Belhaven Realty , LLC		384,627	384,627	21
22	V	34	Rent	1,680,000	Belhaven Realty , LLC			(1,680,000)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,680,000			$ 1,675,216	$ * (4,784)	39

* 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: 01/01/15 Ending: 12/31/15

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			Momence Meadows Nursing & Rehab Ctr	Momence				1
2			Niles Nursing & Rehab Center	Niles				2
3			Oak Lawn Respiratory & Rehab Center	Oak Lawn				3
4			Parker Nursing & Rehab Center	Streator				4
5			Parkshore Estates Nursing & Rehab Ctr	Chicago				5
6			Southpoint Nursing & Rehab Center	Chicago				6
7			West Suburban Nursing & Rehab Center	Bloomingdale				7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Belhaven Nursing & Rehab Ctr # 0048215 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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	First Midwest Mortgage		x	mortgage	Interest Only	5/1/14	$ 18,880,000	$ 18,880,000	4/1/17	3.8500	$ 839,359	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Capital One		x	working capital	None	8/31/14	15,000,000	1,905,847	8/31/18	various	47,925	6
7												7
8												8
9	TOTAL Facility Related						$ 33,880,000	$ 20,785,847			$ 887,284	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 33,880,000	$ 20,785,847			$ 887,284	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: 01/01/15 Ending: 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 211,973	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.)		$ 421,483	2
3. Under or (over) accrual (line 2 minus line 1).		$ 209,510	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 179,646	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.		$ 389,156	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	379,078	8
	2011	377,566	9
	2012	430,741	10
	2013	413,096	11
	2014	421,483	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 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 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 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	25-19-110-040-0000	Nursing Home	$ 421,482.52	$ 421,482.52
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 421,482.52	$ 421,482.52

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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: 01/01/15 Ending: 12/31/15

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).

NONE

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

1. Total Amount Incurred: 2,523,292
2. Number of Years Over Which it is Being Amortized: 15
3. Current Period Amortization: 168,219
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	FACILITY		4/11/2006	$ 1,200,000	1
2					2
3	TOTALS			$ 1,200,000	3

Facility Name & ID Number Belhaven Nursing & Rehab Ctr # 0048215 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 5,996,000	$ 153,744	39	$ 153,744	$ (0)	$ 1,352,459	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Wanderguard Security Camera			7/25/2006	37,000	949	39	949		9,488	9
10	Improvements - Paint & Painting Supplies			10/1/2006	600	15	39	15		152	10
11	2nd Floor Remodeling - Cove Base for Rooms			11/1/2006	1,408	36	39	36		361	11
12	2nd Floor Remodeling - Wall Protection & Corner Guards			11/1/2006	2,372	61	39	61		609	12
13	2nd Floor Remodeling - Floor & Tile			11/1/2006	5,418	139	39	139		1,390	13
14	2nd Floor Remodeling - Paint & Painting Supplies			11/1/2006	14,919	383	39	383		3,827	14
15	2nd Floor Remodeling - Cove Base, Vertical Dividers, Wood Drift			11/1/2006	2,275	58	39	58		582	15
16											16
17	Fast Signs			1/9/2007	3,352	86	39	86		774	17
18	Draperies, Light Fixtures, Cascades			1/23/2007	19,454	499	39	499		4,490	18
19	Painting & Supplies			2/1/2007	1,500	38	39	38		344	19
20	Water Pump & Boiler Tank			2/26/2007	7,156	183	39	183		1,649	20
21	Paint & Supplies			3/1/2007	2,657	68	39	68		613	21
22	Paint & Supplies			4/1/2007	5,520	142	39	142		1,276	22
23	Wall Paper, Wall Protection			5/1/2007	7,306	187	39	187		1,685	23
24	Paint & Supplies			5/1/2007	4,746	122	39	122		1,096	24
25	Heating & Cooling Pump			5/7/2007	4,214	108	39	108		972	25
26	Paint & Supplies			6/1/2007	8,833	226	39	226		2,036	26
27	Air Handler			6/4/2007	6,160	158	39	158		1,422	27
28	Wall Protection & Corner Guards			6/27/2007	7,957	204	39	204		1,836	28
29	Paint & Supplies			7/1/2007	4,744	122	39	122		1,096	29
30	Paint & Supplies			8/1/2007	5,247	135	39	135		1,213	30
31	Electric Work			8/2/2007	5,438	139	39	139		1,253	31
32	A/C			8/8/2007	2,534	65	39	65		585	32
33	Paint & Supplies			9/1/2007	4,393	113	39	113		1,015	33
34	Paint & Supplies			10/1/2007	6,499	167	39	167		1,501	34
35	Lights, Wall Protection, Draperies			10/9/2007	27,168	697	39	697		6,271	35
36	Shower Valve			11/1/2007	3,650	94	39	94		844	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: 01/01/15 Ending: 12/31/15

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	$	$ 710	37
38	Electric Work	11/9/2007	10,269	263	39	263		2,369	38
39	Wall Covering	11/28/2007	3,161	81	39	81		729	39
40	Hydraulic Valve	11/28/2007	4,207	108	39	108		971	40
41	Paint & Supplies	12/1/2007	2,065	53	39	53		477	41
42									42
43	Kickplates/Wallcoverings	1/11/2008	3,130	80	39	80		641	43
44	Kickplates/Wallcoverings	4/24/2008	4,179	107	39	107		857	44
45	Valve Replacement	5/13/2008	3,650	94	39	94		750	45
46	Cooling Tower	6/20/2008	4,093	105	39	105		840	46
47	Water Heater parts replacement	12/5/2008	1,516	39	39	39		312	47
48	Water Heater parts replacement	12/24/2008	969	25	39	25		199	48
49	Dining Room	1/15/2008	3,600	92	39	92		737	49
50	Paint/Remodel	2/5/2008	2,300	59	39	59		472	50
51	2nd Floor Paint/Remodel	4/4/2008	3,000	77	39	77		616	51
52	3rd Floor Paint/Remodel	5/16/2008	3,500	90	39	90		719	52
53	Paint/Remodel	5/22/2008	1,500	38	39	38		306	53
54	Remodel - Cabinets/Light Fixtures	9/12/2008	600	15	39	15		122	54
55	Remodel - Cabinets/Light Fixtures	9/12/2008	1,400	36	39	36		288	55
56	Remodel Supplies	10/14/2008	600	15	39	15		122	56
57	Remodel Supplies	1/15/2008	252	6	39	6		50	57
58	Remodel Supplies	2/5/2008	269	7	39	7		56	58
59	Remodel Supplies	4/14/2008	406	10	39	10		82	59
60	Remodel Supplies	4/21/2008	663	17	39	17		136	60
61	Remodel Supplies	4/23/2008	489	13	39	13		102	61
62	Remodel Supplies	5/16/2008	326	8	39	8		65	62
63	Remodel Supplies	5/22/2008	465	12	39	12		96	63
64	Remodel Supplies	9/11/2008	1,106	28	39	28		225	64
65	Remodel Supplies	9/2/2008	1,470	38	39	38		303	65
66	Remodel Supplies	9/12/2008	606	16	39	16		126	66
67	Elevator	4/10/2008	3,006	77	39	77		616	67
68	Elevator	7/21/2008	5,538	142	39	142		1,136	68
69	Elevator	12/26/2008	4,407	113	39	113		904	69
70	TOTAL (lines 4 thru 69)		$ 6,274,338	$ 160,881		$ 160,881	$ (0)	$ 1,416,973	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: 01/01/15 Ending: 12/31/15

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		$ 6,274,338	$ 160,881		$ 160,881	$ (0)	$ 1,416,973	1
2	Sprinkler Repairs	7/31/2008	537	14	39	14		111	2
3	Sprinkler Repairs	8/28/2008	653	17	39	17		135	3
4	Sprinkler Repairs	8/29/2008	1,510	39	39	39		311	4
5	Sprinkler Repairs	8/31/2008	1,980	51	39	51		407	5
6	Sprinkler Repairs	8/31/2008	1,156	30	39	30		239	6
7									7
8	Floor Tile	8/19/2009	23,845	611	39	611		4,278	8
9	Remove and Replace Floor Tile	7/8/2009	3,000	77	39	77		539	9
10	New Tile in Shower Room	9/28/2009	3,000	77	39	77		539	10
11	Install Sheetrock in Shower Room	11/18/2009	3,000	77	39	77		539	11
12	Install wood paneling, handrails, corner guards	12/30/2009	3,000	77	39	77		539	12
13	Install Doors, Frames, and Glass	10/20/2009	14,489	372	39	372		2,603	13
14	New Doors	4/16/2009	910	23	39	23		162	14
15	New Doors	6/3/2009	1,134	29	39	29		203	15
16	Repair Sinkhole, Repair Pavement, Reseal & Restripe Park.	4/3/2009	9,625	247	39	247		1,728	16
17	New Faucets and Drains	10/7/2009	2,235	57	39	57		400	17
18	New Faucets and Drains	12/28/2009	1,290	33	39	33		231	18
19	New Faucets and Drains	12/21/2009	1,725	44	39	44		309	19
20	New Faucets and Drains	12/21/2009	1,725	44	39	44		309	20
21	New Roofing	9/14/2009	68,755	1,763	39	1,763		12,341	21
22	New Roofing	10/16/2009	1,950	50	39	50		350	22
23	Install and Paint Over Water Lines	6/19/2009	785	20	39	20		140	23
24	Install and Paint Over Water Lines	5/21/2009	1,700	44	39	44		307	24
25	Removal of Old Dooring & Installation of Dura Glides	12/17/2009	12,315	316	39	316		2,211	25
26	Wall Coverings. Wall Tiles, Table Lamps, Ceiling Pendants	12/29/2009	25,004	641	39	641		4,487	26
27									27
28	Drywall & Construction Supplies	10/13/2010	1,302	33	39	33		199	28
29	Shower Remodeling, 2nd Floor	1/20/2010	3,000	77	39	77		462	29
30	Shower Remodeling, 2nd Floor - Fixing Cracked Tiles	2/3/2010	3,000	77	39	77		462	30
31	Replacement Ceiling Tiles	12/7/2010	2,750	71	39	71		425	31
32	Replacement Ceiling Tiles, Paint, Fixing Duct	12/16/2010	2,410	62	39	62		372	32
33	Cleaners, Paints, Door Hinges, Flooring	12/16/2010	1,216	31	39	31		186	33
34	TOTAL (lines 1 thru 33)		$ 6,473,339	$ 165,985		$ 165,985	$ (0)	$ 1,452,497	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: 01/01/15 Ending: 12/31/15

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		$ 6,473,339	$ 165,985		$ 165,985	$ (0)	$ 1,452,497	1
2	Hardware for Doors/Flooring	12/17/2010	1,746	45	39	45		270	2
3	Elevator	8/5/2010	153,000	3,923	39	3,923		27,305	3
4	Hinges, Paint, Glass, and Stainless Steel for Basement	6/24/2010	6,115	157	39	157		942	4
5	Metal Doors Setup	12/9/2010	6,175	158	39	158		949	5
6	Door Locks	12/14/2010	475	12	39	12		72	6
7					39				7
8	Concrete Work	9/27/2011	11,000	282	39	282		2,679	8
9	Concrete & Asphalt Work	9/27/2011	6,750	173	39	173		865	9
10	Asphalt Work	11/12/2011	1,575	40	39	40		200	10
11	Fire Alarm System Devices	5/27/2011	8,506	218	39	218		1,090	11
12	HUD Inspection Preparation	1/5/2011	5,325	137	39	137		685	12
13	Sprinkler Addition in Elevator Pit	9/27/2011	2,575	66	39	66		330	13
14	New Hydronic Heater	1/24/2011	5,470	140	39	140		700	14
15	Chiller Compressor Replacement	4/20/2011	10,300	264	39	264		1,320	15
16	Chiller & Cooling Tower Cleaning	5/4/2011	7,950	204	39	204		1,020	16
17	New Cooling Tower Fan Motor Pulley & Blower Belts	7/6/2011	4,318	111	39	111		555	17
18	Kitchen Air Handler	8/2/2011	1,245	32	39	32		160	18
19	Sewer Dig Up & Repair	6/9/2011	10,500	269	39	269		1,345	19
20	Replaced Broken Pipe& Filled Holes w/ Concrete	7/6/2011	5,200	133	39	133		665	20
21	Remodel Offices- Ceiling Tiles, Flooring, Lighting, Paint	11/30/2011	8,486	218	39	218		1,090	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		13,840	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		40,510	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		14,390	27
28	Remodel PT Room- Lighting, Tile, Paint, Cabinets, Countertops	11/30/2011	36,356	932	39	932		4,660	28
29	Elevators- New Flooring, Wall Panels, Wall Base, Ceiling	11/30/2011	18,834	483	39	483		2,415	29
30	Specialty Consultation re: Safety Code Surveys	6/20/2011	2,905	74	39	74		370	30
31	Develop Fires Saftey Evaluation System	8/25/2011	5,278	135	39	135		675	31
32	Ceiling Panel	1/3/2011	547	14	39	14		70	32
33	Smoke Damper	2/1/2010	3,900	100	39	100		500	33
34	TOTAL (lines 1 thru 33)		$ 7,334,039	$ 188,053		$ 188,053	$ (0)	$ 1,572,169	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: 01/01/15 Ending: 12/31/15

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		$ 7,334,039	$ 188,053		$ 188,053	$ (0)	$ 1,572,169	1
2	Insulated Unit	1/12/2011	760	19	39	19		96	2
3	Insulated Unit	1/25/2011	705	18	39	18		90	3
4	Building Light	11/11/2011	710	18	39	18		90	4
5	Metal Door	1/3/2011	6,560	168	39	168		840	5
6									6
7	Replaced/Reprogrammed Pull Station	1/9/2012	2,834	73	39	73		292	7
8	Sprinkler Work	1/18/2012	4,925	126	39	126		504	8
9	Installed Ductwork necessary for Oxygen Rooms	1/20/2012	4,645	119	39	119		476	9
10	Metal Doors	1/24/2012	1,215	31	39	31		124	10
11	Sales tax on Metal Doors	1/24/2012	85	2	39	2		8	11
12	Repair Roof	2/20/2012	3,600	92	39	92		368	12
13	Install 28 Smoke Detectors & Fire Alarm System	3/21/2012	9,102	233	39	233		932	13
14	Credit for Expense Claimed in PY	3/22/2012	(110,243)	(2,827)	39	(2,827)		(11,308)	14
15	Replace Cast Iron Pipe	4/4/2012	1,400	36	39	36		144	15
16	Mechanical Rooms Repairs	6/18/2012	1,100	28	39	28		112	16
17	Basement Bathroom Ventilation	8/21/2012	4,000	103	39	103		412	17
18	Repair Heating	8/22/2012	3,838	98	39	98		392	18
19	Lever lockset	8/29/2012	811	21	39	21		84	19
20	Lever Lockset	8/29/2012	2,572	66	39	66		264	20
21	Metal Doors	8/30/2012	4,450	114	39	114		456	21
22	Repair Heating	9/10/2012	1,970	51	39	51		204	22
23	New Flooring and walls throughout entire facility	11/1/2012	47,836	1,227	39	1,227		4,908	23
24	Misc Repairs to piping in kitchen	11/2/2012	3,100	79	39	79		316	24
25	Install Precision Lamps on first floor nurses station	11/2/2012	3,551	91	39	91		364	25
26	New Flooring and walls throughout entire facility	12/14/2012	50,586	1,297	39	1,297		5,188	26
27	New Flooring and walls throughout entire facility	12/14/2012	60,320	1,547	39	1,547		6,188	27
28									28
29	Items deleted in FY10 and before capital rate reconciliation		131,542	3,478	39	3,478		16,391	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,576,013	$ 194,361		$ 194,361	$ (0)	$ 1,600,104	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: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 7,576,013	$ 194,361		$ 194,361	$ (0)	$ 1,600,104	1
2	Freezer	2013	4,260	109	39	109		273	2
3	Five Star - Parking Lot	2013	8,750	224	39	224		560	3
4	Fire Alarm System	2013	13,058	335	39	335		837	4
5	Corridors, dining room shades	2013	51,560	1,322	39	1,322		3,305	5
6	Generator	2013	4,708	121	39	121		302	6
7	Floor fixtures 1st & 2nd floor	2013	3,975	102	39	102		255	7
8	Eidco Credit	2013	(50,586)	(1,297)	39	(1,297)		(3,243)	8
9	Sprinkler system	2013	6,299	162	39	162		405	9
10	Survey	2013	2,819	72	39	72		180	10
11	Housekeepers store room/bathroom in basement	2013	25,613	657	39	657		1,643	11
12	lighting in dining room	2013	53,560	1,373	39	1,373		3,433	12
13									13
14	Repair walk-in freezer in kitchen	2014	2,015	52	39	52		74	14
15	Install Imperial Water Booster	2014	3,020	77	39	77		83	15
16	New Asphalt on portion of parking lot next to wood fence	2014	850	22	39	22		44	16
17	Cover base/flooring in main hallway	2014	3,679	94	39	94		141	17
18	Remove existing carpet in lobby and replace	2014	3,001	77	39	77		109	18
19	Security Camera system	2014	5,722	147	39	147		184	19
20	Install cabinetry, mirror, lighting, and sinks in beauty shop	2014	4,400	113	39	113		160	20
21	Chller	2014	6,995	179	39	179		283	21
22	Booster pump	2014	2,498	64	39	64		91	22
23	Boiler & heater	2014	2,057	53	39	53		70	23
24	Floors in beauty shop	2014	1,718	44	39	44		55	24
25	Supply and Install Cat 5E cables in patient rooms	2014	2,844	73	39	73		146	25
26	Take fire system offline, test system and valves, restore	2014	2,214	57	39	57		62	26
27	Washer	2014	9,900	254	39	254		296	27
28	Perform fire services evaluation system test	2014	4,855	124	39	124		228	28
29	Install new flooring and cove base in basement hallways	2014	3,273	84	39	84		161	29
30	Install signage outside of building	2014	6,670	171	39	171		347	30
31	Tile flooring in patient bathrooms	2014	3,476	89	39	89		171	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,769,213	$ 199,315		$ 199,315	$ (0)	$ 1,610,759	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: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 7,769,213	$ 199,315		$ 199,315	$ (0)	$ 1,610,759	1
2									2
3	Custom Cabinets & Walls in Rms 101,103, 117	2015	9,000	217	39	231	14	217	3
4	Hot Water Unit	2015	4,485	108	39	115	7	108	4
5	Fire Sprinkler System Upgrade	2015	4,042	97	39	104	7	97	5
6	Fire Sprinkler System - New Sprinkler Heads	2015	2,570	62	39	66	4	62	6
7	Freezer - Evaporator Coil	2015	3,650	88	39	94	6	88	7
8	Air Conditioner Repair	2015	2,587	62	39	66	4	62	8
9	Fire Alarm Bell, Smoke Detectors, Power Supply	2015	2,711	65	39	70	5	65	9
10	Cooler Tower Floatball and Screens	2015	4,233	102	39	109	7	102	10
11	Cooler Tower R-22 for Compressor	2015	3,080	74	39	79	5	74	11
12	Cooler Tower Sealing	2015	4,233	102	39	109	7	102	12
13	Vinyl Plank Flooring	2015	2,650	64	39	68	4	64	13
14	Cooler Tower Belts and Oiling	2015	2,573	62	39	66	4	62	14
15	Cooler Tower Algaecide Treatment	2015	3,191	77	39	82	5	77	15
16	Basement Water Lines	2015	6,800	164	39	174	10	164	16
17	Dishwasher Repiping of Sanitary Line	2015	3,010	73	39	77	4	73	17
18	Doors in Kitchen	2015	5,338	129	39	137	8	129	18
19	Low Pressure Water Feeder	2015	2,741	66	39	70	4	66	19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,836,107	$ 200,927		$ 201,032	$ 105	$ 1,612,371	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: 01/01/15 Ending: 12/31/15

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	$ 636,000	$ 90,857	$ 97,200	$ 6,343	5	$ 240,857	71
72	Current Year Purchases	56,138	56,138	9,333	(46,805)	5-7	56,138	72
73	Fully Depreciated Assets	775,236		66,040	66,040	5-7	775,236	73
74								74
75	TOTALS	$ 1,467,374	$ 146,995	$ 172,573	$ 25,578		$ 1,072,231	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)	$ 10,503,481	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 347,922	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 373,605	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 25,683	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,684,602	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: 01/01/15 Ending: 12/31/15

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.	/2016	$
13.	/2017	$
14.	/2018	$

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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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	$	7,763	$ 416,383	$	7,763	$ 416,383	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		1,422	96,274		1,422	96,274	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		5,633	357,696		5,633	357,696	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				187,972		187,972	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): XRAY	39-2					13,446		13,446	12
13	Other (specify): LAB	39-2					3,527		3,527	13
14	TOTAL			$	14,818	$ 870,353	$ 204,945	14,818	$ 1,075,298	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: 01/01/15 Ending: 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/15 (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	$ (465,410)	$ (445,806)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	4,780,906	4,860,391	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	274,214	281,203	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	2,415,427	2,415,427	8
9	Other(specify):		261,500	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 7,005,137	$ 7,372,715	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,200,000	13
14	Buildings, at Historical Cost		5,996,000	14
15	Leasehold Improvements, at Historical Cost	1,840,107	1,840,107	15
16	Equipment, at Historical Cost	831,374	1,467,374	16
17	Accumulated Depreciation (book methods)	(1,091,286)	(2,684,602)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		2,523,292	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(2,343,718)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe **Capital Improvement Reserve**		7,906	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,580,195	$ 8,006,359	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,585,332	$ 15,379,074	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,548,115	$ 1,983,103	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	61,051	61,051	28
29	Short-Term Notes Payable		586,248	29
30	Accrued Salaries Payable	204,288	204,288	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		65,600	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Working Capital Note	1,975,927	1,975,927	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,789,381	$ 4,876,217	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		18,293,752	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	IRS Audit Adjustment		362,499	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 18,656,251	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,789,381	$ 23,532,468	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,795,951	$ (8,153,394)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,585,332	$ 15,379,074	48

*(See instructions.)

Facility Name & ID Number Belhaven Nursing & Rehab Ctr # 0048215 Report Period Beginning: 01/01/15 Ending: 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,947,335	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,947,335	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	848,611	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) **Rounding**	5	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 848,616	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)**	$ 4,795,951	24 *

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

Facility Name & ID Number Belhaven Nursing & Rehab Ctr # 0048215 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 14,676,420	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 14,676,420	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	975,529	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 975,529	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	105,816	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,521	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 109,337	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	62,626	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 62,626	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Miscellaneous Revenue	17,191	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 17,191	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 15,841,103	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,959,745	31
32	Health Care	5,878,851	32
33	General Administration	3,206,720	33
	B. Capital Expense		
34	Ownership	1,834,604	34
	C. Ancillary Expense		
35	Special Cost Centers	204,945	35
36	Provider Participation Fee	482,552	36
	D. Other Expenses (specify):		
37	Bad Debt Exp	1,425,000	37
38	Medically Necessary Transportation	75	38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 14,992,492	40
41	**Income before Income Taxes (line 30 minus line 40)****	848,611	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 848,611	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 11,277,587	44
45	Private Pay - Net Inpatient Revenue	326,720	45
46	Medicare - Net Inpatient Revenue	2,006,289	46
47	Other-(specify) Net Inpatient Revenue	1,065,824	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 14,676,420	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: 01/01/15 Ending: 12/31/15

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	1,740	1,789	$ 81,920	$ 45.79	1
2	Assistant Director of Nursing	6,819	7,294	238,977	32.76	2
3	Registered Nurses	14,863	16,868	505,414	29.96	3
4	Licensed Practical Nurses	50,929	58,851	1,616,384	27.47	4
5	CNAs & Orderlies	126,064	142,968	1,594,960	11.16	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	10,607	12,211	141,809	11.61	9
10	Activity Assistants					10
11	Social Service Workers	3,844	4,130	81,438	19.72	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	26,790	29,522	355,753	12.05	15
16	Dishwashers					16
17	Maintenance Workers	5,686	6,318	96,791	15.32	17
18	Housekeepers	26,016	29,236	337,192	11.53	18
19	Laundry	9,472	10,966	140,180	12.78	19
20	Administrator	1,901	1,958	95,641	48.85	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,057	13,851	235,860	17.03	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,961	4,381	63,144	14.41	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	301,749	340,343	$ 5,585,463 *	$ 16.41	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	304	$ 10,642	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	960	33,594	10-3	38
39	Pharmacist Consultant	384	19,188	15-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	842	42,110	10-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	133	4,666	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,623	$ 110,200		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: 01/01/15 Ending: 12/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Caroline Hamilton	Administrator		$ 14,559
Solomon Mirahi	Administrator		81,082
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 95,641

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	$ 10,149
Johnson, Goldberg, & Brown	Accounting	2,500
Infinity	Accounting	209
Law Office of Barbar	Legal	794
Lewis, Brisbois, Bisgaard, & Smith	Legal	267,508
Jonathan Berlin	Legal	2,000
Swanson Martin & Bell	Legal	29,200
London Bernard	Legal	25,000
Clausen Miller	Legal	7,726
various	Legal	3,244
Life Safety Resource	Professional	9,828
Infinity Healthcare	Professional/Mgmt	429,449
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 787,607

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 243,810
Unemployment Compensation Insurance	173,258
FICA Taxes	446,677
Employee Health Insurance	72,904
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
pension exp	15,900
employee expenses	25,820
uniforms	17,334
TOTAL (agree to Schedule V, line 22, col.8)	$ 995,703

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	$ 1,990
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Illinois Council	
Collaborative Health	(200)
City of Chicago Dept of Rev	1,780
Sec of State	250
IHCA	771
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,591

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
auto allowance	2,876
mileage	5,448
continuing education	474
Seminar Expense	(345)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,453

**See instructions.

Facility Name & ID Number Belhaven Nursing & Rehab Ctr # 0048215 Report Period Beginning: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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 on Long Term Care**

(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. $ **67,314** 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. $ **482,552**
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. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

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

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

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

(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.