FOR BHF USE

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2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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: (708) 449-1900 **Fax #** (773) 583-3929

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 01/01/17 to 12/31/17 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) Paresh Vipani
(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: 01/01/17 Ending: 12/31/17

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	57,838	2,658	6,438	66,934	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	57,838	2,658	6,438	66,934	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.98%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve 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 2,253

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: 12/31/17 Fiscal Year: 12/31/17

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

Facility Name & ID Number Belhaven Nursing & Rehab Ctr # 0048215 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	378,035	46,471	18,157	442,663		442,663	(499)	442,164			1
2	Food Purchase		353,705		353,705		353,705	1,627	355,332			2
3	Housekeeping	370,047	74,316		444,363		444,363	492	444,855			3
4	Laundry	131,928	41,701		173,629		173,629		173,629			4
5	Heat and Other Utilities			336,919	336,919		336,919	664	337,583			5
6	Maintenance	87,165	82,129	129,655	298,949		298,949	559	299,508			6
7	Other (specify):*											7
8	TOTAL General Services	967,175	598,322	484,731	2,050,228		2,050,228	2,843	2,053,071			8
	B. Health Care and Programs											
9	Medical Director			17,500	17,500		17,500		17,500			9
10	Nursing and Medical Records	4,400,793	442,676	51,508	4,894,977		4,894,977	4,315	4,899,292			10
10a	Therapy			772,173	772,173		772,173		772,173			10a
11	Activities	139,491	25,239		164,730		164,730		164,730			11
12	Social Services	122,816		12,118	134,934		134,934		134,934			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* RX Consultant			19,808	19,808		19,808	(364)	19,444			15
16	TOTAL Health Care and Programs	4,663,100	467,915	873,107	6,004,122		6,004,122	3,951	6,008,073			16
	C. General Administration											
17	Administrative	103,605			103,605		103,605		103,605			17
18	Directors Fees											18
19	Professional Services			969,185	969,185		969,185	(187,766)	781,419			19
20	Dues, Fees, Subscriptions & Promotions			14,597	14,597		14,597	130	14,727			20
21	Clerical & General Office Expenses	286,636	69,441	127,119	483,196		483,196	146,315	629,511			21
22	Employee Benefits & Payroll Taxes			1,104,220	1,104,220		1,104,220	38,985	1,143,205			22
23	Inservice Training & Education											23
24	Travel and Seminar			15,023	15,023		15,023	4,764	19,787			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			874,329	874,329		874,329	800	875,129			26
27	Other (specify):*											27
28	TOTAL General Administration	390,241	69,441	3,104,473	3,564,155		3,564,155	3,228	3,567,383			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,020,516	1,135,678	4,462,311	11,618,505		11,618,505	10,022	11,628,527			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: 01/01/17 Ending: 12/31/17

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			79,182	79,182		79,182	258,293	337,475			30
31	Amortization of Pre-Op. & Org.							(13,215)	(13,215)			31
32	Interest							597,737	597,737			32
33	Real Estate Taxes			506,177	506,177		506,177	(66,952)	439,225			33
34	Rent-Facility & Grounds			879,504	879,504		879,504	(873,181)	6,323			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Replacement Tax			6,085	6,085		6,085		6,085			36
37	TOTAL Ownership			1,470,948	1,470,948		1,470,948	(97,318)	1,373,630			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			7,719	7,719		7,719		7,719			38
39	Ancillary Service Centers		132,654		132,654		132,654	(2,119)	130,535			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			508,852	508,852		508,852		508,852			42
43	Other (specify):* Bad Debt Exp			787,081	787,081		787,081	(787,081)				43
44	TOTAL Special Cost Centers		132,654	1,303,652	1,436,306		1,436,306	(789,200)	647,106			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,020,516	1,268,332	7,236,911	14,525,759		14,525,759	(876,496)	13,649,263			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: 01/01/17 Ending: 12/31/17

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	82,913	30		9
10	Interest and Other Investment Income	(50,094)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(71)	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	(74)	21		18
19	Entertainment				19
20	Contributions	(7,142)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(787,081)	43		24
25	Fund Raising, Advertising and Promotional	(13,548)	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	(12,971)	various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (788,068)		$	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)	(88,428)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (88,428)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (876,496)		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

Belhaven Nursing & Rehab Ctr

ID# 0048215

Report Period Beginning: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Income	$ (9,554)	21	1
2	PAC Expenses	(730)	20	2
3	RP Profit	(204)	10	3
4	RP Profit	(364)	15	4
5	RP Profit	(2,119)	39	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**	(12,971)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Belhaven Nursing & Rehab Ctr # 0048215 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(71)	(428)	0	0	0	0	0	0	0	0	0	(499)	1
2	Food Purchase	0	1,627	0	0	0	0	0	0	0	0	0	1,627	2
3	Housekeeping	0	492	0	0	0	0	0	0	0	0	0	492	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	664	0	0	0	0	0	0	0	0	0	664	5
6	Maintenance	0	559	0	0	0	0	0	0	0	0	0	559	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(71)	2,914	0	0	0	0	0	0	0	0	0	2,843	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	(204)	4,519	0	0	0	0	0	0	0	0	0	4,315	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):*	(364)	0	0	0	0	0	0	0	0	0	0	(364)	15
16	**TOTAL Health Care and Programs**	(568)	4,519	0	0	0	0	0	0	0	0	0	3,951	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	(220,525)	32,759	0	0	0	0	0	0	0	0	(187,766)	19
20	Fees, Subscriptions & Promotions	(730)	860	0	0	0	0	0	0	0	0	0	130	20
21	Clerical & General Office Expenses	(30,318)	176,326	307	0	0	0	0	0	0	0	0	146,315	21
22	Employee Benefits & Payroll Taxes	0	38,985	0	0	0	0	0	0	0	0	0	38,985	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	4,764	0	0	0	0	0	0	0	0	0	4,764	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	800	0	0	0	0	0	0	0	0	0	800	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(31,048)	1,210	33,066	0	0	0	0	0	0	0	0	3,228	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(31,687)	8,643	33,066	0	0	0	0	0	0	0	0	10,022	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Belhaven Nursing & Rehab Ctr # 0048215 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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	82,913	177	175,203	0	0	0	0	0	0	0	0	258,293	30
31	Amortization of Pre-Op. & Org.	0	0	(13,215)	0	0	0	0	0	0	0	0	(13,215)	31
32	Interest	(50,094)	0	647,831	0	0	0	0	0	0	0	0	597,737	32
33	Real Estate Taxes	0	0	(66,952)	0	0	0	0	0	0	0	0	(66,952)	33
34	Rent-Facility & Grounds	0	0	(873,181)	0	0	0	0	0	0	0	0	(873,181)	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	32,819	177	(130,314)	0	0	0	0	0	0	0	0	(97,318)	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	(2,119)	0	0	0	0	0	0	0	0	0	0	(2,119)	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):*	(787,081)	0	0	0	0	0	0	0	0	0	0	(787,081)	43
44	TOTAL Special Cost Centers	(789,200)	0	0	0	0	0	0	0	0	0	0	(789,200)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(788,068)	8,820	(97,248)	0	0	0	0	0	0	0	0	(876,496)	45

Facility Name & ID Number Belhaven Nursing & Rehab Ctr # 0048215 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 & Rehad 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	United Rx	Hillside	Pharmacy Co.
		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	$ 3,587	Infinity Healthcare Management of Illinois		$ 3,159	$ (428)	1
2	V	2	Food Purchases		Infinity Healthcare Management of Illinois		1,627	1,627	2
3	V	3	Housekeeping		Infinity Healthcare Management of Illinois		492	492	3
4	V	5	Utilities		Infinity Healthcare Management of Illinois		664	664	4
5	V	6	Maintenance		Infinity Healthcare Management of Illinois		559	559	5
6	V	10	Nursing	51,508	Infinity Healthcare Management of Illinois		56,027	4,519	6
7	V	19	Professional Fees	364,652	Infinity Healthcare Management of Illinois		144,127	(220,525)	7
8	V	20	Dues and Fees		Infinity Healthcare Management of Illinois		860	860	8
9	V	21	Office Expense	110,084	Infinity Healthcare Management of Illinois		286,410	176,326	9
10	V	22	Employee Expenses		Infinity Healthcare Management of Illinois		38,985	38,985	10
11	V	24	Travel		Infinity Healthcare Management of Illinois		4,764	4,764	11
12	V	26	Insurance		Infinity Healthcare Management of Illinois		800	800	12
13	V	30	Depreciation		Infinity Healthcare Management of Illinois		177	177	13
14	Total			$ 529,831			$ 538,651	$ * 8,820	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: 01/01/17 Ending: 12/31/17

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	32	Interest	$	Infinity Healthcare Management of Illinois		$ 19	$ 19	15
16	V	34	Rent Expense		Infinity Healthcare Management of Illinois		6,323	6,323	16
17	V								17
18	V	19	Professional Fees		Belhaven Realty, LLC		32,759	32,759	18
19	V	21	Office Expense		Belhaven Realty, LLC		307	307	19
20	V	30	Depreciation		Belhaven Realty, LLC		175,203	175,203	20
21	V	31	Amortization		Belhaven Realty, LLC		(13,215)	(13,215)	21
22	V	32	Interest		Belhaven Realty, LLC		647,812	647,812	22
23	V	33	RE Taxes		Belhaven Realty, LLC		(66,952)	(66,952)	23
24	V	34	Rent	879,504	Belhaven Realty, LLC			(879,504)	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			$ 879,504			$ 782,256	$ * (97,248)	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: 01/01/17 Ending: 12/31/17

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: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		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: 01/01/17 Ending: 12/31/17

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: 01/01/17 Ending: 12/31/17

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	HUD Loan		X	Mortgage	$86,255.00	5/19/16	$ 19,356,000	$ 19,016,225	6/1/46	3.4000	$ 647,831	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$86,255.00		$ 19,356,000	$ 19,016,225			$ 647,831	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 19,356,000	$ 19,016,225			$ 647,831	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:** 01/01/17 **Ending:** 12/31/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 195,899	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.)		$ 501,769	2
3. Under or (over) accrual (line 2 minus line 1).		$ 305,870	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 133,355	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.		$ 439,225	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	430,741	8
	2013	413,096	9
	2014	421,483	10
	2015	459,118	11
	2016	501,769	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 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 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	25-19-110-040-0000	Nursing Home	$ 501,769.43	$ 501,769.43
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 501,769.43	$ 501,769.43

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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: 01/01/17 Ending: 12/31/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 78,730 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

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

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

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

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

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

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

1. Total Amount Incurred: 2,419,619
2. Number of Years Over Which it is Being Amortized: 15
3. Current Period Amortization: (13,215)
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	$ 1,200,000	1
2					2
3	TOTALS			$ 1,200,000	3

Facility Name & ID Number Belhaven Nursing & Rehab Ctr # 0048215 Report Period Beginning: 01/01/17 Ending: 12/31/17

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					$ 5,996,000	$ 153,744	39	$ 153,744	$	$ 1,659,947	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Wanderguard Security Camera			2006	37,000	949	39	949		11,386	9
10	Improvements - Paint & Painting Supplies			2006	600	15	39	15		182	10
11	2nd Floor Remodeling - Cove Base for Rooms			2006	1,408	36	39	36		433	11
12	2nd Floor Remodeling - Wall Protection & Corner Guards			2006	2,372	61	39	61		731	12
13	2nd Floor Remodeling - Floor & Tile			2006	5,418	139	39	139		1,668	13
14	2nd Floor Remodeling - Paint & Painting Supplies			2006	14,919	383	39	383		4,593	14
15	2nd Floor Remodeling - Cove Base, Vertical Dividers, Wood Drift			2006	2,275	58	39	58		698	15
16											16
17	Fast Signs			2007	3,352	86	39	86		946	17
18	Draperies, Light Fixtures, Cascades			2007	19,454	499	39	499		5,488	18
19	Painting & Supplies			2007	1,500	38	39	38		420	19
20	Water Pump & Boiler Tank			2007	7,156	183	39	183		2,015	20
21	Paint & Supplies			2007	2,657	68	39	68		749	21
22	Paint & Supplies			2007	5,520	142	39	142		1,560	22
23	Wall Paper, Wall Protection			2007	7,306	187	39	187		2,059	23
24	Paint & Supplies			2007	4,746	122	39	122		1,340	24
25	Heating & Cooling Pump			2007	4,214	108	39	108		1,188	25
26	Paint & Supplies			2007	8,833	226	39	226		2,488	26
27	Air Handler			2007	6,160	158	39	158		1,738	27
28	Wall Protection & Corner Guards			2007	7,957	204	39	204		2,244	28
29	Paint & Supplies			2007	4,744	122	39	122		1,340	29
30	Paint & Supplies			2007	5,247	135	39	135		1,483	30
31	Electric Work			2007	5,438	139	39	139		1,531	31
32	A/C			2007	2,534	65	39	65		715	32
33	Paint & Supplies			2007	4,393	113	39	113		1,241	33
34	Paint & Supplies			2007	6,499	167	39	167		1,835	34
35	Lights, Wall Protection, Draperies			2007	27,168	697	39	697		7,665	35
36	Shower Valve			2007	3,650	94	39	94		1,032	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: 01/01/17 Ending: 12/31/17

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	2007	$ 3,076	$ 79	39	$ 79	$	$ 868	37
38	Electric Work	2007	10,269	263	39	263		2,895	38
39	Wall Covering	2007	3,161	81	39	81		891	39
40	Hydraulic Valve	2007	4,207	108	39	108		1,187	40
41	Paint & Supplies	2007	2,065	53	39	53		583	41
42									42
43	Kickplates/Wallcoverings	2008	3,130	80	39	80		801	43
44	Kickplates/Wallcoverings	2008	4,179	107	39	107		1,071	44
45	Valve Replacement	2008	3,650	94	39	94		938	45
46	Cooling Tower	2008	4,093	105	39	105		1,050	46
47	Water Heater parts replacement	2008	1,516	39	39	39		390	47
48	Water Heater parts replacement	2008	969	25	39	25		249	48
49	Dining Room	2008	3,600	92	39	92		921	49
50	Paint/Remodel	2008	2,300	59	39	59		590	50
51	2nd Floor Paint/Remodel	2008	3,000	77	39	77		770	51
52	3rd Floor Paint/Remodel	2008	3,500	90	39	90		899	52
53	Paint/Remodel	2008	1,500	38	39	38		382	53
54	Remodel - Cabinets/Light Fixtures	2008	600	15	39	15		152	54
55	Remodel - Cabinets/Light Fixtures	2008	1,400	36	39	36		360	55
56	Remodel Supplies	2008	600	15	39	15		152	56
57	Remodel Supplies	2008	252	6	39	6		62	57
58	Remodel Supplies	2008	269	7	39	7		70	58
59	Remodel Supplies	2008	406	10	39	10		102	59
60	Remodel Supplies	2008	663	17	39	17		170	60
61	Remodel Supplies	2008	489	13	39	13		128	61
62	Remodel Supplies	2008	326	8	39	8		81	62
63	Remodel Supplies	2008	465	12	39	12		120	63
64	Remodel Supplies	2008	1,106	28	39	28		281	64
65	Remodel Supplies	2008	1,470	38	39	38		379	65
66	Remodel Supplies	2008	606	16	39	16		158	66
67	Elevator	2008	3,006	77	39	77		770	67
68	Elevator	2008	5,538	142	39	142		1,420	68
69	Elevator	2008	4,407	113	39	113		1,130	69
70	TOTAL (lines 4 thru 69)		$ 6,274,338	$ 160,881		$ 160,881	$	$ 1,738,735	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: 01/01/17 Ending: 12/31/17

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	$	$ 1,738,735	1
2	Sprinkler Repairs	2008	537	14	39	14		139	2
3	Sprinkler Repairs	2008	653	17	39	17		169	3
4	Sprinkler Repairs	2008	1,510	39	39	39		389	4
5	Sprinkler Repairs	2008	1,980	51	39	51		509	5
6	Sprinkler Repairs	2008	1,156	30	39	30		299	6
7									7
8	Floor Tile	2009	23,845	611	39	611		5,500	8
9	Remove and Replace Floor Tile	2009	3,000	77	39	77		693	9
10	New Tile in Shower Room	2009	3,000	77	39	77		693	10
11	Install Sheetrock in Shower Room	2009	3,000	77	39	77		693	11
12	Install wood paneling, handrails, corner guards	2009	3,000	77	39	77		693	12
13	Install Doors, Frames, and Glass	2009	14,489	372	39	372		3,347	13
14	New Doors	2009	910	23	39	23		208	14
15	New Doors	2009	1,134	29	39	29		261	15
16	Repair Sinkhole, Repair Pavement, Reseal & Restripe Park.	2009	9,625	247	39	247		2,222	16
17	New Faucets and Drains	2009	2,235	57	39	57		514	17
18	New Faucets and Drains	2009	1,290	33	39	33		297	18
19	New Faucets and Drains	2009	1,725	44	39	44		397	19
20	New Faucets and Drains	2009	1,725	44	39	44		397	20
21	New Roofing	2009	68,755	1,763	39	1,763		15,867	21
22	New Roofing	2009	1,950	50	39	50		450	22
23	Install and Paint Over Water Lines	2009	785	20	39	20		180	23
24	Install and Paint Over Water Lines	2009	1,700	44	39	44		395	24
25	Removal of Old Dooring & Installation of Dura Glides	2009	12,315	316	39	316		2,843	25
26	Wall Coverings. Wall Tiles, Table Lamps, Ceiling Pendants	2009	25,004	641	39	641		5,769	26
27									27
28	Drywall & Construction Supplies	2010	1,302	33	39	33		265	28
29	Shower Remodeling, 2nd Floor	2010	3,000	77	39	77		616	29
30	Shower Remodeling, 2nd Floor - Fixing Cracked Tiles	2010	3,000	77	39	77		616	30
31	Replacement Ceiling Tiles	2010	2,750	71	39	71		567	31
32	Replacement Ceiling Tiles, Paint, Fixing Duct	2010	2,410	62	39	62		496	32
33	Cleaners, Paints, Door Hinges, Flooring	2010	1,216	31	39	31		248	33
34	TOTAL (lines 1 thru 33)		$ 6,473,339	$ 165,985		$ 165,985	$	$ 1,784,467	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: 01/01/17 Ending: 12/31/17

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	$	$ 1,784,467	1
2	Hardware for Doors/Flooring	2010	1,746	45	39	45		360	2
3	Elevator	2010	153,000	3,923	39	3,923		35,151	3
4	Hinges, Paint, Glass, and Stainless Steel for Basement	2010	6,115	157	39	157		1,256	4
5	Metal Doors Setup	2010	6,175	158	39	158		1,265	5
6	Door Locks	2010	475	12	39	12		96	6
7									7
8	Concrete Work	2011	11,000	282	39	282		3,243	8
9	Concrete & Asphalt Work	2011	6,750	173	39	173		1,211	9
10	Asphalt Work	2011	1,575	40	39	40		280	10
11	Fire Alarm System Devices	2011	8,506	218	39	218		1,526	11
12	HUD Inspection Preparation	2011	5,325	137	39	137		959	12
13	Sprinkler Addition in Elevator Pit	2011	2,575	66	39	66		462	13
14	New Hydronic Heater	2011	5,470	140	39	140		980	14
15	Chiller Compressor Replacement	2011	10,300	264	39	264		1,848	15
16	Chiller & Cooling Tower Cleaning	2011	7,950	204	39	204		1,428	16
17	New Cooling Tower Fan Motor Pulley & Blower Belts	2011	4,318	111	39	111		777	17
18	Kitchen Air Handler	2011	1,245	32	39	32		224	18
19	Sewer Dig Up & Repair	2011	10,500	269	39	269		1,883	19
20	Replaced Broken Pipe& Filled Holes w/ Concrete	2011	5,200	133	39	133		931	20
21	Remodel Offices- Ceiling Tiles, Flooring, Lighting, Paint	2011	8,486	218	39	218		1,526	21
22	Remodel Nurses Stations- Lighting, Coffered Ceiling, Floor								22
23	Tile, New Work Stations, Sink, Paint	2011	107,949	2,768	39	2,768		19,376	23
24	Remodel Corridors- Lighting, Floor Tile, Ceiling Tile,								24
25	Wallcovering, Handrail, Corner Gauards, Paint Doors	2011	315,993	8,102	39	8,102		56,714	25
26	Remodel Dining Rooms- Lighting, Drywall, Floor Tile, Ceiling								26
27	Tile, Paint, Wallcoverings, Corner Gaurds, Roller Shades	2011	112,227	2,878	39	2,878		20,146	27
28	Remodel PT Room- Lighting, Tile, Paint, Cabinets, Countertops	2011	36,356	932	39	932		6,524	28
29	Elevators- New Flooring, Wall Panels, Wall Base, Ceiling	2011	18,834	483	39	483		3,381	29
30	Specialty Consultation re: Safety Code Surveys	2011	2,905	74	39	74		518	30
31	Develop Fires Saftey Evaluation System	2011	5,278	135	39	135		945	31
32	Ceiling Panel	2011	547	14	39	14		98	32
33	Smoke Damper	2011	3,900	100	39	100		700	33
34	TOTAL (lines 1 thru 33)		$ 7,334,039	$ 188,053		$ 188,053	$	$ 1,948,275	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: 01/01/17 Ending: 12/31/17

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	$	$ 1,948,275	1
2	Insulated Unit	2011	760	19	39	19		134	2
3	Insulated Unit	2011	705	18	39	18		126	3
4	Building Light	2011	710	18	39	18		126	4
5	Metal Door	2011	6,560	168	39	168		1,176	5
6									6
7	Replaced/Reprogrammed Pull Station	2012	2,834	73	39	73		438	7
8	Sprinkler Work	2012	4,925	126	39	126		756	8
9	Installed Ductwork necessary for Oxygen Rooms	2012	4,645	119	39	119		714	9
10	Metal Doors	2012	1,215	31	39	31		186	10
11	Sales tax on Metal Doors	2012	85	2	39	2		12	11
12	Repair Roof	2012	3,600	92	39	92		552	12
13	Install 28 Smoke Detectors & Fire Alarm System	2012	9,102	233	39	233		1,398	13
14	Credit for Expense Claimed in PY	2012	(110,243)	(2,827)	39	(2,827)		(16,962)	14
15	Replace Cast Iron Pipe	2012	1,400	36	39	36		216	15
16	Mechanical Rooms Repairs	2012	1,100	28	39	28		168	16
17	Basement Bathroom Ventilation	2012	4,000	103	39	103		618	17
18	Repair Heating	2012	3,838	98	39	98		588	18
19	Lever lockset	2012	811	21	39	21		126	19
20	Lever Lockset	2012	2,572	66	39	66		396	20
21	Metal Doors	2012	4,450	114	39	114		684	21
22	Repair Heating	2012	1,970	51	39	51		306	22
23	New Flooring and walls throughout entire facility	2012	47,836	1,227	39	1,227		7,362	23
24	Misc Repairs to piping in kitchen	2012	3,100	79	39	79		474	24
25	Install Precision Lamps on first floor nurses station	2012	3,551	91	39	91		546	25
26	New Flooring and walls throughout entire facility	2012	50,586	1,297	39	1,297		7,782	26
27	New Flooring and walls throughout entire facility	2012	60,320	1,547	39	1,547		9,282	27
28									28
29	Items deleted in FY10 and before capital rate reconciliation		131,542	3,373	39	3,373		23,242	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,576,013	$ 194,256		$ 194,256	$	$ 1,988,721	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: 01/01/17 Ending: 12/31/17

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	$ 194,256		$ 194,256	$	$ 1,988,721	1
2	Freezer	2013	4,260	109	39	109		491	2
3	Five Star - Parking Lot	2013	8,750	224	39	224		1,008	3
4	Fire Alarm System	2013	13,058	335	39	335		1,507	4
5	Corridors, dining room shades	2013	51,560	1,322	39	1,322		5,949	5
6	Generator	2013	4,708	121	39	121		544	6
7	Floor fixtures 1st & 2nd floor	2013	3,975	102	39	102		459	7
8	Eidco Credit	2013	(50,586)	(1,297)	39	(1,297)		(5,837)	8
9	Sprinkler system	2013	6,299	162	39	162		729	9
10	Survey	2013	2,819	72	39	72		324	10
11	Housekeepers store room/bathroom in basement	2013	25,613	657	39	657		2,957	11
12	lighting in dining room	2013	53,560	1,373	39	1,373		6,179	12
13									13
14	Repair walk-in freezer in kitchen	2014	2,015	52	39	52		178	14
15	Install Imperial Water Booster	2014	3,020	77	39	77		237	15
16	New Asphalt on portion of parking lot next to wood fence	2014	850	22	39	22		88	16
17	Cover base/flooring in main hallway	2014	3,679	94	39	94		329	17
18	Remove existing carpet in lobby and replace	2014	3,001	77	39	77		263	18
19	Security Camera system	2014	5,722	147	39	147		478	19
20	Install cabinetry, mirror, lighting, and sinks in beauty shop	2014	4,400	113	39	113		386	20
21	Chller	2014	6,995	179	39	179		641	21
22	Booster pump	2014	2,498	64	39	64		219	22
23	Boiler & heater	2014	2,057	53	39	53		176	23
24	Floors in beauty shop	2014	1,718	44	39	44		143	24
25	Supply and Install Cat 5E cables in patient rooms	2014	2,844	73	39	73		292	25
26	Take fire system offline, test system and valves, restore	2014	2,214	57	39	57		176	26
27	Washer	2014	9,900	254	39	254		804	27
28	Perform fire services evaluation system test	2014	4,855	124	39	124		476	28
29	Install new flooring and cove base in basement hallways	2014	3,273	84	39	84		329	29
30	Install signage outside of building	2014	6,670	171	39	171		689	30
31	Tile flooring in patient bathrooms	2014	3,476	89	39	89		349	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,769,213	$ 199,210		$ 199,210	$	$ 2,009,284	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: 01/01/17 Ending: 12/31/17

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	$ 199,210		$ 199,210	$	$ 2,009,284	1
2									2
3	Custom Cabinets & Walls in Rms 101,103, 117	2015	9,000	231	39	231		679	3
4	Hot Water Unit	2015	4,485	115	39	115		338	4
5	Fire Sprinkler System Upgrade	2015	4,042	104	39	104		305	5
6	Fire Sprinkler System - New Sprinkler Heads	2015	2,570	66	39	66		194	6
7	Freezer - Evaporator Coil	2015	3,650	94	39	94		276	7
8	Air Conditioner Repair	2015	2,587	66	39	66		194	8
9	Fire Alarm Bell, Smoke Detectors, Power Supply	2015	2,711	70	39	70		205	9
10	Cooler Tower Floatball and Screens	2015	4,233	109	39	109		320	10
11	Cooler Tower R-22 for Compressor	2015	3,080	79	39	79		232	11
12	Cooler Tower Sealing	2015	4,233	109	39	109		320	12
13	Vinyl Plank Flooring	2015	2,650	68	39	68		200	13
14	Cooler Tower Belts and Oiling	2015	2,573	66	39	66		194	14
15	Cooler Tower Algaecide Treatment	2015	3,191	82	39	82		241	15
16	Basement Water Lines	2015	6,800	174	39	174		512	16
17	Dishwasher Repiping of Sanitary Line	2015	3,010	77	39	77		227	17
18	Doors in Kitchen	2015	5,338	137	39	137		403	18
19	Low Pressure Water Feeder	2015	2,741	70	39	70		206	19
20									20
21	Repairs and Seal Coating	2016	17,205	441	39	441		865	21
22	Fire Alarm System / Repairs	2016	7,818	200	39	200		392	22
23	New Cooling Tower	2016	39,996	1,026	39	1,026		2,011	23
24	Repair Freon leak on unit	2016	7,876	202	39	202		396	24
25	Paint/Repair 1st floor doors	2016	8,160	209	39	209		410	25
26	Install new doors - 3rd floor	2016	11,338	291	39	291		571	26
27	Flooring repairs / tiling - 2nd Floor	2016	3,275	84	39	84		165	27
28	Doors - 3rd floor East Stairwell	2016	2,710	69	39	69		135	28
29	Doors - Rooms 232, 316 and 1st Floor Patio	2016	4,498	115	39	115		225	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,938,983	$ 203,564		$ 203,564	$	$ 2,019,500	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: 01/01/17 Ending: 12/31/17

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 12F, Carried Forward		$ 7,938,983	$ 203,564		$ 203,564	$	$ 2,019,500	1
2	1st Floor, 2nd Floor, 3rd Floor Doors	2017	4,160	53	39	53		53	2
3	New OEM Boiler Orifices	2017	4,462	57	39	57		57	3
4	Doors for Rm 133,Business Office,Smoking Patio	2017	5,949	76	39	76		76	4
5	New Air Compressor	2017	6,500	84	39	84		84	5
6	Basement Floor Alarm System & 1st floor Annunciator	2017	2,880	37	39	37		37	6
7	Caulk Exterior Windows	2017	4,124	53	39	53		53	7
8	Upgrade to 3rd Floor Bathroom	2017	5,785	74	39	74		74	8
9	New Base Cabinets for Pantry Rooms & Nursing Station	2017	5,800	74	39	74		74	9
10	New Doors for Rooms 233,203,218,3rd Floor Activity Room,330,229	2017	12,383	159	39	159		159	10
11	Retube Boiler	2017	19,500	250	39	250		250	11
12	Front Entrance Security System	2017	4,195	54	39	54		54	12
13	New Cable for 1st Floor TV	2017	5,989	77	39	77		77	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,020,710	$ 204,612		$ 204,612	$	$ 2,020,548	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: 01/01/17 Ending: 12/31/17

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	$ 21,637	$ 127,200	$ 105,563	5	$ 422,573	71
72	Current Year Purchases	28,313	28,313	5,663	(22,650)	5	28,313	72
73	Fully Depreciated Assets	876,103				5	876,103	73
74								74
75	TOTALS	$ 1,540,416	$ 49,950	$ 132,863	$ 82,913		$ 1,326,989	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)	$ 10,761,126	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 254,562	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 337,475	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 82,913	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,347,537	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: 01/01/17 Ending: 12/31/17

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. [X] YES [ ] NO

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

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.		$
13.		$
14.		$

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: *

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: 01/01/17 Ending: 12/31/17

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: 01/01/17 Ending: 12/31/17

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	$	5,375	$ 295,685	$	5,375	$ 295,685	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		1,869	140,802		1,869	140,802	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		5,120	335,686		5,120	335,686	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				116,966		116,966	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): X-Ray	39-2					9,555		9,555	12
13	Other (specify): Lab	39-2					6,133		6,133	13
14	TOTAL			$	12,364	$ 772,173	$ 132,654	12,364	$ 904,827	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.

Facility Name & ID Number Belhaven Nursing & Rehab Ctr **#** 0048215 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/17 **(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	$ (166,788)	$ 1,101,715	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,777,720	3,777,720	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	574,012	580,314	6
7	Other Prepaid Expenses	2,875	2,875	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Escrow Accounts	688,145	879,445	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,875,964	$ 6,342,069	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	2,024,710	2,024,710	15
16	Equipment, at Historical Cost	904,416	1,540,416	16
17	Accumulated Depreciation (book methods)	(1,265,018)	(3,347,537)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		2,587,949	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(2,498,722)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Replacement Res	138,185	138,185	22
23	Other(specify): Long Term Receivable	6,793,192	6,967,849	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 8,595,485	$ 14,608,850	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 13,471,449	$ 20,950,919	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 5,322,655	$ 5,666,247	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	58,945	58,945	28
29	Short-Term Notes Payable		540,494	29
30	Accrued Salaries Payable	222,002	222,002	30
31	Accrued Taxes Payable (excluding real estate taxes)	29,906	29,906	31
32	Accrued Real Estate Taxes(Sch.IX-B)	735,736	735,736	32
33	Accrued Interest Payable		53,480	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Settlement Reserve	77,538	77,538	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 6,446,782	$ 7,384,348	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		18,475,731	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)**	$	$ 18,475,731	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,446,782	$ 25,860,079	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 7,024,667	$ (4,909,160)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 13,471,449	$ 20,950,919	48

***(See instructions.)**

Facility Name & ID Number Belhaven Nursing & Rehab Ctr # 0048215 Report Period Beginning: 01/01/17 Ending: 12/31/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 5,953,444	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 5,953,444	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,071,223	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,071,223	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)**	$ 7,024,667	24 *

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

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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	$ 14,209,260	1
2	Discounts and Allowances for all Levels	813,188	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 15,022,448	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	453,008	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 453,008	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	48,401	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,249	19
20	Radiology and X-Ray	5,300	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 63,950	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	48,022	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 48,022	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	9,554	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 9,554	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 15,596,982	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,050,225	31
32	Health Care	6,004,123	32
33	General Administration	3,564,157	33
	B. Capital Expense		
34	Ownership	1,470,948	34
	C. Ancillary Expense		
35	Special Cost Centers	140,373	35
36	Provider Participation Fee	508,852	36
	D. Other Expenses (specify):		
37		787,081	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 14,525,759	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,071,223	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,071,223	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 12,126,742	44
45	Private Pay - Net Inpatient Revenue	578,064	45
46	Medicare - Net Inpatient Revenue	1,287,716	46
47	Other-(specify)	1,029,927	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 15,022,449	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.**

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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	1,423	1,522	$ 86,941	$ 57.12	1
2	Assistant Director of Nursing	7,809	8,555	316,050	36.94	2
3	Registered Nurses	14,552	16,013	475,540	29.70	3
4	Licensed Practical Nurses	56,217	61,604	1,785,531	28.98	4
5	CNAs & Orderlies	127,892	139,360	1,638,957	11.76	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	9,436	10,484	139,491	13.31	9
10	Activity Assistants					10
11	Social Service Workers	6,068	6,580	122,816	18.67	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	25,435	27,806	378,035	13.60	15
16	Dishwashers					16
17	Maintenance Workers	4,435	4,774	87,165	18.26	17
18	Housekeepers	26,865	29,578	370,047	12.51	18
19	Laundry	8,290	9,416	131,928	14.01	19
20	Administrator	2,087	2,209	103,605	46.90	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,306	15,631	286,636	18.34	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	2,107	2,244	43,104	19.21	31
32	Other Health Care(specify)					32
33	Other(specify) Admissions Coord	1,812	2,383	54,670	22.94	33
34	TOTAL (lines 1 - 33)	308,734	338,159	$ 6,020,516 *	$ 17.80	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	519	$ 18,157	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	1,472	51,508	10-3	38
39	Pharmacist Consultant	396	19,808	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	157	5,495	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,544	$ 94,968		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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Brad Fierce	Administrator		$ 103,605
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 103,605

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	$ 11,756
Johnson & Goldburg	Accounting	3,900
Infinity Funding/Sedgwick	Legal	436,846
Lewis, Brisbois, Bisgaard, & Smith	Legal	67,887
Myers, Carden, & Sax LLC	Legal	15,625
Swanson, Martin, & Bell LLP	Legal	8,941
Various Legal	Legal	19,069
Healthcare Recruiting Specialists	Professional	6,240
Life Safety Resources	Professional	2,544
MTS Consulting	Professional	19,375
Infinity Healthcare	Professional/Mgmt	364,652
Empire Risk	Professional/Mgmt	12,350
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 969,185

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 271,013
Unemployment Compensation Insurance	171,215
FICA Taxes	442,908
Employee Health Insurance	188,264
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension Expense	16,325
Uniform Expense	7,081
Employee Expense	7,414
Other Employee Benefits	38,985
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,143,205

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,105
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
IHCA	11,727
City of Chicago	1,035
Infinity Healthcare	860
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,727

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Mileage	14,105
Travel Allowance	4,764
Seminar Expense	
Education & Seminars	918
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 19,787

* Attach copy of IMRF notifications

**See instructions.

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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 - 11,727**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(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. $ **97,524** 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.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **508,852**
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