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.

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

I. IDPH License ID Number: 0048215

Facility Name: Belhaven Nursing and Rehabilitation Center, LLC

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
  - [ ] Charitable Corp.
  - [ ] Trust
- IRS Exemption Code
- [X] PROPRIETARY
  - [ ] Individual
  - [ ] Partnership
  - [ ] Corporation
  - [ ] "Sub-S" Corp.
  - [X] Limited Liability Co.
  - [ ] Trust
  - [ ] Other
- [ ] GOVERNMENTAL
  - [ ] State
  - [ ] County
  - [ ] Other

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/18 to 12/31/18 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

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

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 and Rehabilitation Center, LLC # 0048215 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	61,200	1,597	3,648	66,445	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	61,200	1,597	3,648	66,445	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.37%

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 2,159

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: 12/31/18 Fiscal Year: 12/31/18

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

STATE OF ILLINOIS

Facility Name & ID Number: Belhaven Nursing and Rehabilitation Center, # 0048215 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	406,430	49,536	18,480	474,446		474,446	(46)	474,400			1
2	Food Purchase		394,056		394,056		394,056	1,954	396,010			2
3	Housekeeping	358,242	66,324		424,566		424,566	21	424,587			3
4	Laundry	159,729	48,964		208,693		208,693		208,693			4
5	Heat and Other Utilities			349,639	349,639		349,639	3,228	352,867			5
6	Maintenance	95,552	59,616	138,811	293,979		293,979	1,770	295,749			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,019,953	618,496	506,930	2,145,379		2,145,379	6,927	2,152,306			8
	B. Health Care and Programs											
9	Medical Director			24,500	24,500		24,500		24,500			9
10	Nursing and Medical Records	4,274,120	477,255	51,508	4,802,883		4,802,883	6,163	4,809,046			10
10a	Therapy			768,329	768,329		768,329		768,329			10a
11	Activities	164,682	15,568		180,250		180,250		180,250			11
12	Social Services	138,038		6,925	144,963		144,963		144,963			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* RX Consultant			19,710	19,710		19,710	1,421	21,131			15
16	**TOTAL Health Care and Programs**	4,576,840	492,823	870,972	5,940,635		5,940,635	7,584	5,948,219			16
	C. General Administration											
17	Administrative	110,001			110,001		110,001		110,001			17
18	Directors Fees											18
19	Professional Services			1,041,982	1,041,982		1,041,982	(514,795)	527,187			19
20	Dues, Fees, Subscriptions & Promotions			7,094	7,094		7,094	(723)	6,371			20
21	Clerical & General Office Expenses	244,315	66,658	128,124	439,097		439,097	181,154	620,251			21
22	Employee Benefits & Payroll Taxes			1,086,372	1,086,372		1,086,372	48,695	1,135,067			22
23	Inservice Training & Education											23
24	Travel and Seminar			12,755	12,755		12,755	1,362	14,117			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			1,006,110	1,006,110		1,006,110	1,722	1,007,832			26
27	Other (specify):*											27
28	**TOTAL General Administration**	354,316	66,658	3,282,437	3,703,411		3,703,411	(282,585)	3,420,826			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,951,109	1,177,977	4,660,339	11,789,425		11,789,425	(268,074)	11,521,351			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			81,558	81,558		81,558	254,957	336,515			30
31	Amortization of Pre-Op. & Org.							9,287	9,287			31
32	Interest			(958,374)	(958,374)		(958,374)	1,412,315	453,941			32
33	Real Estate Taxes			527,514	527,514		527,514	(50,144)	477,370			33
34	Rent-Facility & Grounds			936,700	936,700		936,700	(930,310)	6,390			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Replacement Tax			5,656	5,656		5,656		5,656			36
37	TOTAL Ownership			593,054	593,054		593,054	696,105	1,289,159			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			11,096	11,096		11,096		11,096			38
39	Ancillary Service Centers		116,771		116,771		116,771	(2,318)	114,453			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			510,043	510,043		510,043		510,043			42
43	Other (specify):* Bad Debt			217,970	217,970		217,970	(217,970)				43
44	TOTAL Special Cost Centers		116,771	739,109	855,880		855,880	(220,288)	635,592			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,951,109	1,294,748	5,992,502	13,238,359		13,238,359	207,743	13,446,102			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 and Rehabilitation Center, LLC # 0048215 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	10,355	30		9
10	Interest and Other Investment Income	(186,079)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(46)	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	(6,960)	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	(217,970)	43		24
25	Fund Raising, Advertising and Promotional	(15,386)	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	955,084	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 538,998		$	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)	(331,255)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (331,255)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 207,743		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

Belhaven Nursing and Rehabilitation Center, LLC

ID# 0048215

Report Period Beginning: 1/1/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	PAC Expenses	$ (132)	20	1
2	Miscellaneous Income	(285)	21	2
3	Miscellaneous Income	(2,165)	10	3
4	RP Profit	189	10	4
5	RP Profit	1,421	15	5
6	RP Profit	(2,318)	39	6
7	Interest Expense	958,374	32	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**	955,084		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Belhaven Nursing and Rehabilitation Center, LLC # 0048215 Report Period Beginning: 1/1/18 Ending: 12/31/18

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(46)	0	0	0	0	0	0	0	0	0	0	(46)	1
2	Food Purchase	0	1,954	0	0	0	0	0	0	0	0	0	1,954	2
3	Housekeeping	0	21	0	0	0	0	0	0	0	0	0	21	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	3,228	0	0	0	0	0	0	0	0	0	3,228	5
6	Maintenance	0	1,770	0	0	0	0	0	0	0	0	0	1,770	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(46)	6,973	0	0	0	0	0	0	0	0	0	6,927	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	(1,976)	8,139	0	0	0	0	0	0	0	0	0	6,163	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):*	1,421	0	0	0	0	0	0	0	0	0	0	1,421	15
16	**TOTAL Health Care and Programs**	(555)	8,139	0	0	0	0	0	0	0	0	0	7,584	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	(549,520)	34,725	0	0	0	0	0	0	0	0	(514,795)	19
20	Fees, Subscriptions & Promotions	(132)	(591)	0	0	0	0	0	0	0	0	0	(723)	20
21	Clerical & General Office Expenses	(22,631)	203,657	128	0	0	0	0	0	0	0	0	181,154	21
22	Employee Benefits & Payroll Taxes	0	48,695	0	0	0	0	0	0	0	0	0	48,695	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,362	0	0	0	0	0	0	0	0	0	1,362	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	1,722	0	0	0	0	0	0	0	0	0	1,722	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(22,763)	(294,675)	34,853	0	0	0	0	0	0	0	0	(282,585)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(23,364)	(279,563)	34,853	0	0	0	0	0	0	0	0	(268,074)	29

Facility Name & ID Number Belhaven Nursing and Rehabilitation Center, LLC # 0048215 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	10,355	0	244,602	0	0	0	0	0	0	0	0	254,957	30
31	Amortization of Pre-Op. & Org.	0	0	9,287	0	0	0	0	0	0	0	0	9,287	31
32	Interest	772,295	0	640,020	0	0	0	0	0	0	0	0	1,412,315	32
33	Real Estate Taxes	0	0	(50,144)	0	0	0	0	0	0	0	0	(50,144)	33
34	Rent-Facility & Grounds	0	0	(930,310)	0	0	0	0	0	0	0	0	(930,310)	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**	782,650	0	(86,545)	0	0	0	0	0	0	0	0	696,105	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	(2,318)	0	0	0	0	0	0	0	0	0	0	(2,318)	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):*	(217,970)	0	0	0	0	0	0	0	0	0	0	(217,970)	43
44	**TOTAL Special Cost Centers**	(220,288)	0	0	0	0	0	0	0	0	0	0	(220,288)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	538,998	(279,563)	(51,692)	0	0	0	0	0	0	0	0	207,743	45

Facility Name & ID Number Belhaven Nursing and Rehabilitation Center, LLC # 0048215 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	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	$	Infinity Healthcare Management of Illinois		$	$	1
2	V	2	Food Purchases		Infinity Healthcare Management of Illinois		1,954	1,954	2
3	V	3	Housekeeping		Infinity Healthcare Management of Illinois		21	21	3
4	V	5	Utilities		Infinity Healthcare Management of Illinois		3,228	3,228	4
5	V	6	Maintenance		Infinity Healthcare Management of Illinois		1,770	1,770	5
6	V	10	Nursing	51,821	Infinity Healthcare Management of Illinois		59,960	8,139	6
7	V	12	Social Services		Infinity Healthcare Management of Illinois				7
8	V	19	Professional Fees	552,256	Infinity Healthcare Management of Illinois		2,736	(549,520)	8
9	V	20	Dues and Fees	780	Infinity Healthcare Management of Illinois		189	(591)	9
10	V	21	Office Expense	130,872	Infinity Healthcare Management of Illinois		334,529	203,657	10
11	V	22	Employee Expense	2,228	Infinity Healthcare Management of Illinois		50,923	48,695	11
12	V	24	Travel	4,695	Infinity Healthcare Management of Illinois		6,057	1,362	12
13	V	26	Insurance		Infinity Healthcare Management of Illinois		1,722	1,722	13
14	Total			$ 742,652			$ 463,089	$ * (279,563)	14

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

Facility Name & ID Number Belhaven Nursing and Rehabilitation Center, LLC # 0048215 Report Period Beginning: 1/1/18 Ending: 12/31/18

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	32	Interest	$	Infinity Healthcare Management of Illinois		$ 5,582	$ 5,582	15
16	V	34	Rent Expense		Infinity Healthcare Management of Illinois		6,389	6,389	16
17	V								17
18	V	19	Professional Fees		Belhaven Realty, LLC		3,700	3,700	18
19	V	19	Legal Fees		Belhaven Realty, LLC		31,025	31,025	19
20	V	21	Office Expense		Belhaven Realty, LLC		128	128	20
21	V	30	Depreciation		Belhaven Realty, LLC		244,602	244,602	21
22	V	31	Amortization		Belhaven Realty, LLC		9,287	9,287	22
23	V	32	Interest		Belhaven Realty, LLC		634,438	634,438	23
24	V	33	RE Taxes		Belhaven Realty, LLC		(50,144)	(50,144)	24
25	V	34	Rent	936,699				(936,699)	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			$ 936,699			$ 885,007	$ * (51,692)	39

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

Facility Name & ID Number Belhaven Nursing and Rehabilitation Center, LLC # 0048215 Report Period Beginning: 1/1/18 Ending: 12/31/18

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			Landmark of Des Plaines	Des Plaines				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 and Rehabilitation Center # 0048215 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	
					Compensation Received From Other	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	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 and Rehabilitation Center, LLC # 0048215 Report Period Beginning: 1/1/18 Ending: 12/31/18

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 and Rehabilitation Center, # 0048215 Report Period Beginning: 1/1/18 Ending: 12/31/18

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	HUD Loan		X	Mortgage	$86,255.00	5/19/16	$ 19,356,000	$ 18,475,731	6/1/46	3.4000	$ 640,020	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	$ 18,475,731			$ 640,020	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	$ 18,475,731			$ 640,020	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 1,722 Line # 26

* 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 and Rehabilitation Center, LLC # 0048215 Report Period Beginning: 1/1/18 Ending: 12/31/18

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Line	Description		Amount	
1	1. Real Estate Tax accrual used on 2017 report.	$	133,355	1
2	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.)	$	539,205	2
3	3. Under or (over) accrual (line 2 minus line 1).	$	405,850	3
4	4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	$	71,520	4
5	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	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	7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	477,370	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

Year	Amount	Line
2013	413,096	8
2014	421,483	9
2015	459,118	10
2016	501,769	11
2017	539,205	12

FOR BHF USE ONLY

Line	Description			Line
13	FROM R. E. TAX STATEMENT FOR 2017	$		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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Belhaven Nursing and Rehabilitation Center, LLC 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 2017 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 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	25-19-110-040-0000	Nursing Home	$ 539,205.30	$ 539,205.30
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 539,205.30	$ 539,205.30

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 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: 173,352
2. Number of Years Over Which it is Being Amortized: 15
3. Current Period Amortization: 9,288
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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1			4/11/2006	$ 1,200,000	1
2					2
3	TOTALS			$ 1,200,000	3

Facility Name & ID Number Belhaven Nursing and Rehabilitation Center, LLC # 0048215 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	$	$ 1,813,691	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Wanderguard Security Camera			2006	37,000	949	39	949		12,335	9
10	Improvements - Paint & Painting Supplies			2006	600	15	39	15		197	10
11	2nd Floor Remodeling - Cove Base for Rooms			2006	1,408	36	39	36		469	11
12	2nd Floor Remodeling - Wall Protection & Corner Guards			2006	2,372	61	39	61		792	12
13	2nd Floor Remodeling - Floor & Tile			2006	5,418	139	39	139		1,807	13
14	2nd Floor Remodeling - Paint & Painting Supplies			2006	14,919	383	39	383		4,976	14
15	2nd Floor Remodeling - Cove Base, Vertical Dividers, Wood Drift			2006	2,275	58	39	58		756	15
16											16
17	Fast Signs			2007	3,352	86	39	86		1,032	17
18	Draperies, Light Fixtures, Cascades			2007	19,454	499	39	499		5,987	18
19	Painting & Supplies			2007	1,500	38	39	38		458	19
20	Water Pump & Boiler Tank			2007	7,156	183	39	183		2,198	20
21	Paint & Supplies			2007	2,657	68	39	68		817	21
22	Paint & Supplies			2007	5,520	142	39	142		1,702	22
23	Wall Paper, Wall Protection			2007	7,306	187	39	187		2,246	23
24	Paint & Supplies			2007	4,746	122	39	122		1,462	24
25	Heating & Cooling Pump			2007	4,214	108	39	108		1,296	25
26	Paint & Supplies			2007	8,833	226	39	226		2,714	26
27	Air Handler			2007	6,160	158	39	158		1,896	27
28	Wall Protection & Corner Guards			2007	7,957	204	39	204		2,448	28
29	Paint & Supplies			2007	4,744	122	39	122		1,462	29
30	Paint & Supplies			2007	5,247	135	39	135		1,618	30
31	Electric Work			2007	5,438	139	39	139		1,670	31
32	A/C			2007	2,534	65	39	65		780	32
33	Paint & Supplies			2007	4,393	113	39	113		1,354	33
34	Paint & Supplies			2007	6,499	167	39	167		2,002	34
35	Lights, Wall Protection, Draperies			2007	27,168	697	39	697		8,362	35
36	Shower Valve			2007	3,650	94	39	94		1,126	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 and Rehabilitation Center, LLC # 0048215 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	$	$ 947	37
38	Electric Work	2007	10,269	263	39	263		3,158	38
39	Wall Covering	2007	3,161	81	39	81		972	39
40	Hydraulic Valve	2007	4,207	108	39	108		1,295	40
41	Paint & Supplies	2007	2,065	53	39	53		636	41
42									42
43	Kickplates/Wallcoverings	2008	3,130	80	39	80		881	43
44	Kickplates/Wallcoverings	2008	4,179	107	39	107		1,178	44
45	Valve Replacement	2008	3,650	94	39	94		1,032	45
46	Cooling Tower	2008	4,093	105	39	105		1,155	46
47	Water Heater parts replacement	2008	1,516	39	39	39		429	47
48	Water Heater parts replacement	2008	969	25	39	25		274	48
49	Dining Room	2008	3,600	92	39	92		1,013	49
50	Paint/Remodel	2008	2,300	59	39	59		649	50
51	2nd Floor Paint/Remodel	2008	3,000	77	39	77		847	51
52	3rd Floor Paint/Remodel	2008	3,500	90	39	90		989	52
53	Paint/Remodel	2008	1,500	38	39	38		420	53
54	Remodel - Cabinets/Light Fixtures	2008	600	15	39	15		167	54
55	Remodel - Cabinets/Light Fixtures	2008	1,400	36	39	36		396	55
56	Remodel Supplies	2008	600	15	39	15		167	56
57	Remodel Supplies	2008	252	6	39	6		68	57
58	Remodel Supplies	2008	269	7	39	7		77	58
59	Remodel Supplies	2008	406	10	39	10		112	59
60	Remodel Supplies	2008	663	17	39	17		187	60
61	Remodel Supplies	2008	489	13	39	13		141	61
62	Remodel Supplies	2008	326	8	39	8		89	62
63	Remodel Supplies	2008	465	12	39	12		132	63
64	Remodel Supplies	2008	1,106	28	39	28		309	64
65	Remodel Supplies	2008	1,470	38	39	38		417	65
66	Remodel Supplies	2008	606	16	39	16		174	66
67	Elevator	2008	3,006	77	39	77		847	67
68	Elevator	2008	5,538	142	39	142		1,562	68
69	Elevator	2008	4,407	113	39	113		1,243	69
70	TOTAL (lines 4 thru 69)		$ 6,274,338	$ 160,881		$ 160,881	$	$ 1,899,616	70

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

Facility Name & ID Number Belhaven Nursing and Rehabilitation Center, LLC # 0048215 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	$	$ 1,899,616	1
2	Sprinkler Repairs	2008	537	14	39	14		153	2
3	Sprinkler Repairs	2008	653	17	39	17		186	3
4	Sprinkler Repairs	2008	1,510	39	39	39		428	4
5	Sprinkler Repairs	2008	1,980	51	39	51		560	5
6	Sprinkler Repairs	2008	1,156	30	39	30		329	6
7									7
8	Floor Tile	2009	23,845	611	39	611		6,111	8
9	Remove and Replace Floor Tile	2009	3,000	77	39	77		770	9
10	New Tile in Shower Room	2009	3,000	77	39	77		770	10
11	Install Sheetrock in Shower Room	2009	3,000	77	39	77		770	11
12	Install wood paneling, handrails, corner guards	2009	3,000	77	39	77		770	12
13	Install Doors, Frames, and Glass	2009	14,489	372	39	372		3,719	13
14	New Doors	2009	910	23	39	23		231	14
15	New Doors	2009	1,134	29	39	29		290	15
16	Repair Sinkhole, Repair Pavement, Reseal & Restripe Park.	2009	9,625	247	39	247		2,469	16
17	New Faucets and Drains	2009	2,235	57	39	57		571	17
18	New Faucets and Drains	2009	1,290	33	39	33		330	18
19	New Faucets and Drains	2009	1,725	44	39	44		441	19
20	New Faucets and Drains	2009	1,725	44	39	44		441	20
21	New Roofing	2009	68,755	1,763	39	1,763		17,630	21
22	New Roofing	2009	1,950	50	39	50		500	22
23	Install and Paint Over Water Lines	2009	785	20	39	20		200	23
24	Install and Paint Over Water Lines	2009	1,700	44	39	44		439	24
25	Removal of Old Dooring & Installation of Dura Glides	2009	12,315	316	39	316		3,159	25
26	Wall Coverings. Wall Tiles, Table Lamps, Ceiling Pendants	2009	25,004	641	39	641		6,410	26
27									27
28	Drywall & Construction Supplies	2010	1,302	33	39	33		298	28
29	Shower Remodeling, 2nd Floor	2010	3,000	77	39	77		693	29
30	Shower Remodeling, 2nd Floor - Fixing Cracked Tiles	2010	3,000	77	39	77		693	30
31	Replacement Ceiling Tiles	2010	2,750	71	39	71		638	31
32	Replacement Ceiling Tiles, Paint, Fixing Duct	2010	2,410	62	39	62		558	32
33	Cleaners, Paints, Door Hinges, Flooring	2010	1,216	31	39	31		279	33
34	TOTAL (lines 1 thru 33)		$ 6,473,339	$ 165,985		$ 165,985	$	$ 1,950,452	34

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

Facility Name & ID Number Belhaven Nursing and Rehabilitation Center, LLC # 0048215 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	$	$ 1,950,452	1
2	Hardware for Doors/Flooring	2010	1,746	45	39	45		405	2
3	Elevator	2010	153,000	3,923	39	3,923		39,074	3
4	Hinges, Paint, Glass, and Stainless Steel for Basement	2010	6,115	157	39	157		1,413	4
5	Metal Doors Setup	2010	6,175	158	39	158		1,423	5
6	Door Locks	2010	475	12	39	12		108	6
7									7
8	Concrete Work	2011	11,000	282	39	282		3,525	8
9	Concrete & Asphalt Work	2011	6,750	173	39	173		1,384	9
10	Asphalt Work	2011	1,575	40	39	40		320	10
11	Fire Alarm System Devices	2011	8,506	218	39	218		1,744	11
12	HUD Inspection Preparation	2011	5,325	137	39	137		1,096	12
13	Sprinkler Addition in Elevator Pit	2011	2,575	66	39	66		528	13
14	New Hydronic Heater	2011	5,470	140	39	140		1,120	14
15	Chiller Compressor Replacement	2011	10,300	264	39	264		2,112	15
16	Chiller & Cooling Tower Cleaning	2011	7,950	204	39	204		1,632	16
17	New Cooling Tower Fan Motor Pulley & Blower Belts	2011	4,318	111	39	111		888	17
18	Kitchen Air Handler	2011	1,245	32	39	32		256	18
19	Sewer Dig Up & Repair	2011	10,500	269	39	269		2,152	19
20	Replaced Broken Pipe& Filled Holes w/ Concrete	2011	5,200	133	39	133		1,064	20
21	Remodel Offices- Ceiling Tiles, Flooring, Lighting, Paint	2011	8,486	218	39	218		1,744	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		22,144	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		64,816	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		23,024	27
28	Remodel PT Room- Lighting, Tile, Paint, Cabinets, Countertops	2011	36,356	932	39	932		7,456	28
29	Elevators- New Flooring, Wall Panels, Wall Base, Ceiling	2011	18,834	483	39	483		3,864	29
30	Specialty Consultation re: Safety Code Surveys	2011	2,905	74	39	74		592	30
31	Develop Fires Saftey Evaluation System	2011	5,278	135	39	135		1,080	31
32	Ceiling Panel	2011	547	14	39	14		112	32
33	Smoke Damper	2011	3,900	100	39	100		800	33
34	TOTAL (lines 1 thru 33)		$ 7,334,039	$ 188,053		$ 188,053	$	$ 2,136,328	34

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

Facility Name & ID Number Belhaven Nursing and Rehabilitation Center, LLC # 0048215 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	$	$ 2,136,328	1
2	Insulated Unit	2011	760	19	39	19		153	2
3	Insulated Unit	2011	705	18	39	18		144	3
4	Building Light	2011	710	18	39	18		144	4
5	Metal Door	2011	6,560	168	39	168		1,344	5
6									6
7	Replaced/Reprogrammed Pull Station	2012	2,834	73	39	73		511	7
8	Sprinkler Work	2012	4,925	126	39	126		882	8
9	Installed Ductwork necessary for Oxygen Rooms	2012	4,645	119	39	119		833	9
10	Metal Doors	2012	1,215	31	39	31		217	10
11	Sales tax on Metal Doors	2012	85	2	39	2		14	11
12	Repair Roof	2012	3,600	92	39	92		644	12
13	Install 28 Smoke Detectors & Fire Alarm System	2012	9,102	233	39	233		1,631	13
14	Credit for Expense Claimed in PY	2012	(110,243)	(2,827)	39	(2,827)		(19,789)	14
15	Replace Cast Iron Pipe	2012	1,400	36	39	36		252	15
16	Mechanical Rooms Repairs	2012	1,100	28	39	28		196	16
17	Basement Bathroom Ventilation	2012	4,000	103	39	103		721	17
18	Repair Heating	2012	3,838	98	39	98		686	18
19	Lever lockset	2012	811	21	39	21		147	19
20	Lever Lockset	2012	2,572	66	39	66		462	20
21	Metal Doors	2012	4,450	114	39	114		798	21
22	Repair Heating	2012	1,970	51	39	51		357	22
23	New Flooring and walls throughout entire facility	2012	47,836	1,227	39	1,227		8,589	23
24	Misc Repairs to piping in kitchen	2012	3,100	79	39	79		553	24
25	Install Precision Lamps on first floor nurses station	2012	3,551	91	39	91		637	25
26	New Flooring and walls throughout entire facility	2012	50,586	1,297	39	1,297		9,079	26
27	New Flooring and walls throughout entire facility	2012	60,320	1,547	39	1,547		10,829	27
28									28
29	Items deleted in FY10 and before capital rate reconciliation		131,542	3,373	39	3,373		27,106	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,576,013	$ 194,256		$ 194,256	$	$ 2,183,468	34

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

Facility Name & ID Number Belhaven Nursing and Rehabilitation Center, LLC # 0048215 Report Period Beginning: 1/1/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 7,576,013	$ 194,256		$ 194,256	$	$ 2,183,468	1
2	Freezer	2013	4,260	109	39	109		600	2
3	Five Star - Parking Lot	2013	8,750	224	39	224		1,232	3
4	Fire Alarm System	2013	13,058	335	39	335		1,842	4
5	Corridors, dining room shades	2013	51,560	1,322	39	1,322		7,271	5
6	Generator	2013	4,708	121	39	121		665	6
7	Floor fixtures 1st & 2nd floor	2013	3,975	102	39	102		561	7
8	Eidco Credit	2013	(50,586)	(1,297)	39	(1,297)		(7,134)	8
9	Sprinkler system	2013	6,299	162	39	162		891	9
10	Survey	2013	2,819	72	39	72		396	10
11	Housekeepers store room/bathroom in basement	2013	25,613	657	39	657		3,614	11
12	lighting in dining room	2013	53,560	1,373	39	1,373		7,552	12
13									13
14	Repair walk-in freezer in kitchen	2014	2,015	52	39	52		230	14
15	Install Imperial Water Booster	2014	3,020	77	39	77		314	15
16	New Asphalt on portion of parking lot next to wood fence	2014	850	22	39	22		110	16
17	Cover base/flooring in main hallway	2014	3,679	94	39	94		423	17
18	Remove existing carpet in lobby and replace	2014	3,001	77	39	77		340	18
19	Security Camera system	2014	5,722	147	39	147		625	19
20	Install cabinetry, mirror, lighting, and sinks in beauty shop	2014	4,400	113	39	113		499	20
21	Chller	2014	6,995	179	39	179		820	21
22	Booster pump	2014	2,498	64	39	64		283	22
23	Boiler & heater	2014	2,057	53	39	53		229	23
24	Floors in beauty shop	2014	1,718	44	39	44		187	24
25	Supply and Install Cat 5E cables in patient rooms	2014	2,844	73	39	73		365	25
26	Take fire system offline, test system and valves, restore	2014	2,214	57	39	57		233	26
27	Washer	2014	9,900	254	39	254		1,058	27
28	Perform fire services evaluation system test	2014	4,855	124	39	124		600	28
29	Install new flooring and cove base in basement hallways	2014	3,273	84	39	84		413	29
30	Install signage outside of building	2014	6,670	171	39	171		860	30
31	Tile flooring in patient bathrooms	2014	3,476	89	39	89		438	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,769,213	$ 199,210		$ 199,210	$	$ 2,208,985	34

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

Facility Name & ID Number Belhaven Nursing and Rehabilitation Center, LLC # 0048215 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	$	$ 2,208,985	1
2									2
3	Custom Cabinets & Walls in Rms 101,103, 117	2015	9,000	231	39	231		910	3
4	Hot Water Unit	2015	4,485	115	39	115		453	4
5	Fire Sprinkler System Upgrade	2015	4,042	104	39	104		409	5
6	Fire Sprinkler System - New Sprinkler Heads	2015	2,570	66	39	66		260	6
7	Freezer - Evaporator Coil	2015	3,650	94	39	94		370	7
8	Air Conditioner Repair	2015	2,587	66	39	66		260	8
9	Fire Alarm Bell, Smoke Detectors, Power Supply	2015	2,711	70	39	70		275	9
10	Cooler Tower Floatball and Screens	2015	4,233	109	39	109		429	10
11	Cooler Tower R-22 for Compressor	2015	3,080	79	39	79		311	11
12	Cooler Tower Sealing	2015	4,233	109	39	109		429	12
13	Vinyl Plank Flooring	2015	2,650	68	39	68		268	13
14	Cooler Tower Belts and Oiling	2015	2,573	66	39	66		260	14
15	Cooler Tower Algaecide Treatment	2015	3,191	82	39	82		323	15
16	Basement Water Lines	2015	6,800	174	39	174		686	16
17	Dishwasher Repiping of Sanitary Line	2015	3,010	77	39	77		304	17
18	Doors in Kitchen	2015	5,338	137	39	137		540	18
19	Low Pressure Water Feeder	2015	2,741	70	39	70		276	19
20									20
21	Repairs and Seal Coating	2016	17,205	441	39	441		1,323	21
22	Fire Alarm System / Repairs	2016	7,818	200	39	200		600	22
23	New Cooling Tower	2016	39,996	1,026	39	1,026		3,078	23
24	Repair Freon leak on unit	2016	7,876	202	39	202		606	24
25	Paint/Repair 1st floor doors	2016	8,160	209	39	209		627	25
26	Install new doors - 3rd floor	2016	11,338	291	39	291		873	26
27	Flooring repairs / tiling - 2nd Floor	2016	3,275	84	39	84		252	27
28	Doors - 3rd floor East Stairwell	2016	2,710	69	39	69		207	28
29	Doors - Rooms 232, 316 and 1st Floor Patio	2016	4,498	115	39	115		345	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,938,983	$ 203,564		$ 203,564	$	$ 2,223,659	34

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

Facility Name & ID Number Belhaven Nursing and Rehabilitation Center, LLC # 0048215 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	$	$ 2,223,659	1
2	1st Floor, 2nd Floor, 3rd Floor Doors	2017	4,160	53	39	53		160	2
3	New OEM Boiler Orifices	2017	4,462	57	39	57		171	3
4	Doors for Rm 133,Business Office,Smoking Patio	2017	5,949	76	39	76		229	4
5	New Air Compressor	2017	6,500	84	39	84		250	5
6	Basement Floor Alarm System & 1st floor Annunciator	2017	2,880	37	39	37		111	6
7	Caulk Exterior Windows	2017	4,124	53	39	53		159	7
8	Upgrade to 3rd Floor Bathroom	2017	5,785	74	39	74		222	8
9	New Base Cabinets for Pantry Rooms & Nursing Station	2017	5,800	74	39	74		223	9
10	New Doors for Rooms 233,203,218,3rd Floor Activity Room,330,229	2017	12,383	159	39	159		477	10
11	Retube Boiler	2017	19,500	250	39	250		750	11
12	Front Entrance Security System	2017	4,195	54	39	54		162	12
13	New Cable for 1st Floor TV	2017	5,989	77	39	77		231	13
14									14
15	New Floor Tile for MDS Office, Social Services Office & Room 118	2018	6,100	78	39	78		78	15
16	New Building Exit Signs	2018	9,400	121	39	121		121	16
17	Replace Main Air Handler Heating Coils	2018	19,919	255	39	255		255	17
18	Paint All Rooms on Second Floor	2018	18,050	231	39	231		231	18
19	Vacuum & Hydro-Jet double Grease Pit & Lift Station	2018	3,489	45	39	45		45	19
20	Vacuum & Hydro-Jet double Grease Pit & Lift Station	2018	2,911	37	39	37		37	20
21	New Lt Fixtures for !st, 2nd, and 3rd Floor Dining Rooms	2018	7,938	102	39	102		102	21
22	New Door for 2nd Floor Social Services Office								22
23	Ice Machines for 1st and 2nd Floors	2018	3,253	42	39	42		42	23
24	New Kitchen Hot Water Tank	2018	3,087	40	39	40		40	24
25	Paint 1st, 2nd, & 3rd Floor Dinign Rooms	2018	13,187	169	39	169		169	25
26	Replace Two Relays on Chiller	2018	2,684	34	39	34		34	26
27	Install New Circuit Breaker to Compressor 3	2018	3,663	47	39	47		47	27
28	Remove and Re-tile Tile Around Shower Base Wall	2018	4,840	62	39	62		62	28
29	Install New Door Hinges for Rooms 202,204,208,211,302,333	2018	3,460	44	39	44		44	29
30	Central Supply, Housekeepiong Office								30
31	Cubcle Curtains	2018	11,324	145	39	145		145	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,134,015	$ 206,064		$ 206,064	$	$ 2,228,256	34

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

Facility Name & ID Number Belhaven Nursing and Rehabilitation Center, LLC # 0048215 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	$ 92,502	$ 127,200	$ 34,698	5	$ 513,429	71
72	Current Year Purchases	27,594	27,594	5,519	(22,075)	5	27,594	72
73	Fully Depreciated Assets	904,416				5	904,416	73
74								74
75	TOTALS	$ 1,568,010	$ 120,096	$ 132,719	$ 12,623		$ 1,445,439	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)	$ 10,902,025	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 326,160	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 338,783	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 12,623	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,673,695	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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.	/2019	$
13.	/2020	$
14.	/2021	$

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.

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

Facility Name & ID Number Belhaven Nursing and Rehabilitation Center, LLC # 0048215 Report Period Beginning: 1/1/18 Ending: 12/31/18

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.

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

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-3	hrs	$	5,456	$ 316,237	$	5,456	$ 316,237	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		1,700	115,756		1,700	115,756	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		5,484	336,336		5,484	336,336	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				109,835		109,835	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): X-Ray	39-2					4,670		4,670	12
13	Other (specify): Lab	39-2					2,266		2,266	13
14	TOTAL			$	12,640	$ 768,329	$ 116,771	12,640	$ 885,100	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 and Rehabilitation Center, LLC # 0048215 Report Period Beginning: 1/1/18 Ending: 12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/18 (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	$ (143,645)	$ 3,957	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,617,718	2,617,718	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	629,394	629,394	6
7	Other Prepaid Expenses	223	223	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	1,189,915	1,251,157	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,293,605	$ 4,502,449	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	2,138,014	2,138,014	15
16	Equipment, at Historical Cost	932,010	1,568,010	16
17	Accumulated Depreciation (book methods)	(1,346,576)	(3,673,696)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		2,591,353	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(2,511,413)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe **Restricted Funds**	126,458	(2,815)	22
23	Other(specify): Long Term Receivable	7,901,242	8,080,679	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 9,751,148	$ 15,386,132	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 14,044,753	$ 19,888,581	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 7,973,259	$ 8,182,511	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	53,160	53,160	28
29	Short-Term Notes Payable		413,290	29
30	Accrued Salaries Payable	260,528	260,528	30
31	Accrued Taxes Payable (excluding real estate taxes)	24,975	24,975	31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,263,250	1,263,250	32
33	Accrued Interest Payable		52,348	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Settlement Reserve	(4,784,259)	(4,784,259)	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,790,913	$ 5,465,803	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		18,062,441	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 18,062,441	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,790,913	$ 23,528,244	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 9,253,840	$ (3,639,663)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 14,044,753	$ 19,888,581	48

*(See instructions.)

Facility Name & ID Number Belhaven Nursing and Rehabilitation Center, LLC # 0048215 Report Period Beginning: 1/1/18 Ending: 12/31/18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 7,024,666	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 7,024,666	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,229,174	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)**	$ 2,229,174	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)**	$ 9,253,840	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	$ 13,891,288	1
2	Discounts and Allowances for all Levels	843,271	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 14,734,559	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	48,400	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)**	$ 63,949	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	178,097	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 178,097	26
	E. Other Revenue (specify):*****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Miscellaneous Income	37,920	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 37,920	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 15,467,533	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,144,207	31
32	Health Care	5,935,368	32
33	General Administration	3,709,850	33
	B. Capital Expense		
34	Ownership	593,054	34
	C. Ancillary Expense		
35	Special Cost Centers	127,867	35
36	Provider Participation Fee	510,043	36
	D. Other Expenses (specify):		
37		217,970	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,238,359	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,229,174	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,229,174	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 12,761,888	44
45	Private Pay - Net Inpatient Revenue	359,325	45
46	Medicare - Net Inpatient Revenue	1,303,604	46
47	Other-(specify)	309,742	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 14,734,559	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	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,986	2,173	$ 119,914	$ 55.18	1
2	Assistant Director of Nursing	8,007	8,868	314,423	35.46	2
3	Registered Nurses	8,381	9,211	288,992	31.37	3
4	Licensed Practical Nurses	51,803	57,004	1,901,549	33.36	4
5	CNAs & Orderlies	99,296	108,855	1,586,299	14.57	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	14,295	15,732	164,682	10.47	9
10	Activity Assistants					10
11	Social Service Workers	2,004	2,230	138,038	61.90	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	26,731	28,746	406,429	14.14	15
16	Dishwashers					16
17	Maintenance Workers	5,086	5,548	95,552	17.22	17
18	Housekeepers	23,975	26,492	358,242	13.52	18
19	Laundry	8,598	9,867	159,729	16.19	19
20	Administrator	2,059	2,154	110,001	51.07	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,082	14,268	244,315	17.12	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	1,269	1,390	29,298	21.08	31
32	Other Health Care(specify)					32
33	Other(specify) Admissions Cord	1,188	1,353	33,646	24.87	33
34	TOTAL (lines 1 - 33)	267,760	293,891	$ 5,951,109 *	$ 20.25	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	528	$ 18,480	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	394	19,710	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	118	4,134	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,512	$ 93,832		49

C. CONTRACT NURSES

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

Facility Name & ID Number: Belhaven Nursing and Rehabilitation Center, LLC # 0048215 Report Period Beginning: 1/1/18 Ending: 12/31/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Brad Fierce	Administrator		$ 74,492
Philip Birn	Administrator		35,509
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 110,001

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	$ 12,000
Swanson, Martin & Bell	Legal	17,992
Carden & Sax LLC	Legal	12,048
Quintairos, Prieto, Wood & Boyer	Legal	8,323
Infinity Funding / Sedgewick	Legal	432,907
Various	Legal	12,671
MTS Consulting Inc	Professional	(18,926)
Infinity Healthcare	Professional	4,974
Empire Risk Management Services L	Professional/Mgmt	14,100
Infinity Healthcare Management LL(	Professional/Mgmt	545,894
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 1,041,982

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 304,128
Unemployment Compensation Insurance	60,996
FICA Taxes	465,795
Employee Health Insurance	264,200
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension Expense	17,390
Employee Expense	12,807
Uniform Expense	7,381
Employee Background Check	2,370
Other Employee Expense	
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,135,067

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	$ 2,652
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
IHCA	1,959
City of Chicago	1,050
Infinity Healthcare	230
Fox Valley Fire and Safety	300
Other	180
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,371

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Mileage	11,744
Auto Allowance	1,362
Seminar Expense	
Education & Seminars	1,011
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 14,117

**See instructions.

Facility Name & ID Number Belhaven Nursing and Rehabilitation Center, LLC # 0048215 **Report Period Beginning:** 1/1/18 **Ending:** 12/31/18

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 Health Care Association - $1050**

(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. $ **197,505** 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. $ **510,043**
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 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