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.

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

I. IDPH License ID Number: 0048215

Facility Name: Belhaven Nursing Rehab Ctr

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

County: Cook

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

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Aaron Mauer **Telephone Number:** 773-747-4506
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/20 to 12/31/20 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) 3/5/2021 (Date)
(Print Name and Title) Aaron Mauer, President
(Firm Name & Address) GGM Associates, Inc., 6101 Nimtz Parkway South Bend IN 46628
(Telephone) 773-747-4506 Fax # 773-747-4725

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: 1/1/20 Ending: 12/31/20

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 NA

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	55,103	338	5,578	61,019	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	55,103	338	5,578	61,019	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.64%

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 3,771

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/20 Fiscal Year: 12/31/20

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

Facility Name & ID Number Belhaven Nursing Rehab Ctr # 0048215 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	491,156	49,770	19,424	560,350		560,350	(11)	560,339			1
2	Food Purchase		402,733		402,733		402,733		402,733			2
3	Housekeeping	782,562	74,980		857,542		857,542		857,542			3
4	Laundry	124,643	52,395		177,038		177,038		177,038			4
5	Heat and Other Utilities			377,311	377,311		377,311	2,569	379,880			5
6	Maintenance	109,305	67,438	94,842	271,585		271,585	(2,111)	269,474			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,507,666	647,316	491,577	2,646,559		2,646,559	447	2,647,006			8
	B. Health Care and Programs											
9	Medical Director			22,500	22,500		22,500		22,500			9
10	Nursing and Medical Records	5,101,660	467,853	53,139	5,622,652		5,622,652	(242,216)	5,380,436			10
10a	Therapy			745,407	745,407		745,407	(28)	745,379			10a
11	Activities	192,400	29,438		221,838		221,838	(1,800)	220,038			11
12	Social Services	145,827		6,356	152,183		152,183		152,183			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* RX Consultant			17,595	17,595		17,595	(424)	17,171			15
16	**TOTAL Health Care and Programs**	5,439,887	497,291	844,997	6,782,175		6,782,175	(244,468)	6,537,707			16
	C. General Administration											
17	Administrative	131,110		4,541	135,651		135,651	69,931	205,582			17
18	Directors Fees											18
19	Professional Services			1,155,199	1,155,199		1,155,199	225,250	1,380,449			19
20	Dues, Fees, Subscriptions & Promotions			5,392	5,392		5,392	106	5,498			20
21	Clerical & General Office Expenses	227,709	55,642	510,814	794,165		794,165	111,041	905,206			21
22	Employee Benefits & Payroll Taxes			955,195	955,195		955,195	51,307	1,006,502			22
23	Inservice Training & Education											23
24	Travel and Seminar			19,591	19,591		19,591	13,706	33,297			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			1,775,453	1,775,453		1,775,453	61,367	1,836,820			26
27	Other (specify):*											27
28	**TOTAL General Administration**	358,819	55,642	4,426,185	4,840,646		4,840,646	532,709	5,373,355			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	7,306,372	1,200,249	5,762,759	14,269,380		14,269,380	288,688	14,558,068			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: 1/1/20 Ending: 12/31/20

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			76,939	76,939		76,939	268,024	344,963			30
31	Amortization of Pre-Op. & Org.			13,638	13,638		13,638	7,019	20,657			31
32	Interest			(1,322,863)	(1,322,863)		(1,322,863)	589,109	(733,754)			32
33	Real Estate Taxes			608,810	608,810		608,810		608,810			33
34	Rent-Facility & Grounds			1,056,288	1,056,288		1,056,288	(1,050,078)	6,210			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Replacement Tax			6,721	6,721		6,721	(6,721)				36
37	TOTAL Ownership			439,533	439,533		439,533	(192,647)	246,886			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			7,810	7,810		7,810		7,810			38
39	Ancillary Service Centers		83,577		83,577		83,577	(1,772)	81,805			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			467,458	467,458		467,458		467,458			42
43	Other (specify):* Bad Debt			273,163	273,163		273,163	(273,163)				43
44	TOTAL Special Cost Centers		83,577	748,431	832,008		832,008	(274,935)	557,073			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,306,372	1,283,826	6,950,723	15,540,921		15,540,921	(178,894)	15,362,027			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: 1/1/20 Ending: 12/31/20

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 Reference	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	21,072	30		9
10	Interest and Other Investment Income	(14,988)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(11)	1		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(3,210)	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	(273,163)	43		24
25	Fund Raising, Advertising and Promotional	(6,206)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(6,721)	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(10,553)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (293,780)		$	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)			34
35	Other- Attach Schedule	114,886	Various	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 114,886		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (178,894)		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.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					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: 1/1/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	RP Profit	$ (333)	10	1
2	RP Profit	(424)	15	2
3	RP Profit	(1,772)	39	3
4	Misc Income - Vendor Rebate	(2,921)	6	4
5	Misc Income - Med Records	(3,274)	10	5
6	Misc Income - Vendor Refund	(28)	10a	6
7	Misc Income - Donation	(1,800)	11	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**	(10,553)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Belhaven Nursing Rehab Ctr # 0048215 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	(11)	0	0	0	0	0	0	0	0	0	0	(11)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	2,569	0	0	0	0	0	0	0	0	0	2,569	5
6	Maintenance	(2,921)	810	0	0	0	0	0	0	0	0	0	(2,111)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,932)	3,379	0	0	0	0	0	0	0	0	0	447	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	(3,607)	(238,609)	0	0	0	0	0	0	0	0	0	(242,216)	10
10a	Therapy	(28)	0	0	0	0	0	0	0	0	0	0	(28)	10a
11	Activities	(1,800)	0	0	0	0	0	0	0	0	0	0	(1,800)	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):*	(424)	0	0	0	0	0	0	0	0	0	0	(424)	15
16	**TOTAL Health Care and Programs**	(5,859)	(238,609)	0	0	0	0	0	0	0	0	0	(244,468)	16
	C. General Administration													
17	Administrative	0	69,931	0	0	0	0	0	0	0	0	0	69,931	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	166,129	59,121	0	0	0	0	0	0	0	0	225,250	19
20	Fees, Subscriptions & Promotions	0	106	0	0	0	0	0	0	0	0	0	106	20
21	Clerical & General Office Expenses	(9,416)	120,457	0	0	0	0	0	0	0	0	0	111,041	21
22	Employee Benefits & Payroll Taxes	0	51,307	0	0	0	0	0	0	0	0	0	51,307	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	13,706	0	0	0	0	0	0	0	0	0	13,706	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	2,723	58,644	0	0	0	0	0	0	0	0	61,367	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(9,416)	424,360	117,765	0	0	0	0	0	0	0	0	532,709	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(18,208)	189,131	117,765	0	0	0	0	0	0	0	0	288,688	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Belhaven Nursing Rehab Ctr # 0048215 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	21,072	82	246,870	0	0	0	0	0	0	0	0	268,024	30
31	Amortization of Pre-Op. & Org.	0	0	7,019	0	0	0	0	0	0	0	0	7,019	31
32	Interest	(14,988)	6,840	597,257	0	0	0	0	0	0	0	0	589,109	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	6,210	(1,056,288)	0	0	0	0	0	0	0	0	(1,050,078)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(6,721)	0	0	0	0	0	0	0	0	0	0	(6,721)	36
37	TOTAL Ownership	(637)	13,132	(205,142)	0	0	0	0	0	0	0	0	(192,647)	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	(1,772)	0	0	0	0	0	0	0	0	0	0	(1,772)	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):*	(273,163)	0	0	0	0	0	0	0	0	0	0	(273,163)	43
44	TOTAL Special Cost Centers	(274,935)	0	0	0	0	0	0	0	0	0	0	(274,935)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(293,780)	202,263	(87,377)	0	0	0	0	0	0	0	0	(178,894)	45

Facility Name & ID Number Belhaven Nursing Rehab Ctr # 0048215 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	Colsulting Co.
GELP	35	City View Nursing & Rehab Center	Cicero	Belhaven Realty, LLC		Realty Co.
A & F Realty, LLC	30	Continental Nursing & Rehab Center	Chicago	United Rx	Hillside	Pharmacy Co.
		Forest View Nursing & Rehab 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	5	Heat and Other Utilities	$	Infinity Healthcare Management of IL LLC		$ 2,569	$ 2,569	1
2	V	6	Maintenance	652	Infinity Healthcare Management of IL LLC		1,462	810	2
3	V	10	Nursing and Medical Records	313,629	Infinity Healthcare Management of IL LLC		75,020	(238,609)	3
4	V	17	Administrative	1,182	Infinity Healthcare Management of IL LLC		71,113	69,931	4
5	V	19	Professional Services	597,989	Infinity Healthcare Management of IL LLC		764,118	166,129	5
6	V	20	Dues, Fees, Subscriptions & Promotion	77	Infinity Healthcare Management of IL LLC		183	106	6
7	V	21	Clerical & General Office Expenses	141,889	Infinity Healthcare Management of IL LLC		262,346	120,457	7
8	V	22	Employee Benefits & Payroll Taxes	9	Infinity Healthcare Management of IL LLC		51,316	51,307	8
9	V	24	Travel and Seminar	3,908	Infinity Healthcare Management of IL LLC		17,614	13,706	9
10	V	26	Insurance-Prop.Liab.Malpractice		Infinity Healthcare Management of IL LLC		2,723	2,723	10
11	V	30	Depreciation		Infinity Healthcare Management of IL LLC		82	82	11
12	V	32	Interest		Infinity Healthcare Management of IL LLC		6,840	6,840	12
13	V	34	Rent-Facility & Grounds		Infinity Healthcare Management of IL LLC		6,210	6,210	13
14	Total			$ 1,059,335			$ 1,261,598	$ * 202,263	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: 1/1/20 Ending: 12/31/20

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. ☐ 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	34	Rent	$ 1,056,288	Belhaven Realty, LLC		$	$ (1,056,288)	15
16	V	31	Amortization		Belhaven Realty, LLC		7,019	7,019	16
17	V	30	Depreciation		Belhaven Realty, LLC		246,870	246,870	17
18	V	19	Professional Services		Belhaven Realty, LLC		59,121	59,121	18
19	V	26	Insurance		Belhaven Realty, LLC		58,644	58,644	19
20	V	32	Interest		Belhaven Realty, LLC		597,257	597,257	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,056,288			$ 968,911	$ * (87,377)	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: 1/1/20 Ending: 12/31/20

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 Nrusing & 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	Streater				4
5			Parkshore Estates Nursing & Rehab Ctr	Chicago				5
6			Southpoint Nursing & Rehab Center	Chicago				6
7			West Suburban Nursing & Rehab Center	Bloomington				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 Rehab Ctr # 0048215 Report Period Beginning: 1/1/20 Ending: 12/31/20

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: 1/1/20 Ending: 12/31/20

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 ☐

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: 1/1/20 Ending: 12/31/20

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		X	Mortgage	$79,864.00	5/19/16	$ 19,356,000	$ 17,671,065	6/1/46	2.6900	$ 557,433	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Infinity H Funding	X		Working Capital	None	Various	Various	Various	None	Various	58	6
7												7
8												8
9	TOTAL Facility Related				$79,864.00		$ 19,356,000	$ 17,671,065			$ 557,491	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	$ 17,671,065			$ 557,491	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 58,644 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 Rehab Ctr # 0048215 Report Period Beginning: 1/1/20 Ending: 12/31/20

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 164,521	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.)		$ 548,738	2
3. Under or (over) accrual (line 2 minus line 1).		$ 384,217	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 224,593	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.		$ 608,810	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	459,118	8
	2016	449,391	9
	2017	482,919	10
	2018	539,452	11
	2019	548,738	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2019	$	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.

2019 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 Aaron Mauer

TELEPHONE 773-747-4506 FAX #: 773-747-4725

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

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	25-19-110-040-0000	Nursing Home	$ 548,738.09	$ 548,738.09
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 548,738.09	$ 548,738.09

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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: 1/1/20 Ending: 12/31/20

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? [ ] (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: 7,019 4. Dates Incurred: Prior to 4/11/2006

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: 1/1/20 Ending: 12/31/20

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	$	$ 2,121,179	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Wandergaurd Security Camera			2006	37,000	949	39	949		14,232	9
10	Improvements - Paint & Painting Supplies			2006	600	15	39	15		228	10
11	2nd Floor Remodeling - Cove Base for Rooms			2006	1,408	36	39	36		541	11
12	2nd Floor Remodeling - Wall Protection & Corner Guards			2006	2,372	61	39	61		914	12
13	2nd Floor Remodeling - Floor & Tile			2006	5,418	139	39	139		2,085	13
14	2nd Floor Remodeling - Paint & Painting Supplies			2006	14,919	383	39	383		5,741	14
15	2nd Floor Remodeling - Cove Base, Vertical Dividers, Wood Drift			2006	2,275	58	39	58		873	15
16											16
17	Fast Signs			2007	3,352	86	39	86		1,204	17
18	Draperies, Light Fixtures, Cascades			2007	19,454	499	39	499		6,985	18
19	Painting & Supplies			2007	1,500	38	39	38		535	19
20	Water Pump & Boiler Tank			2007	7,156	183	39	183		2,565	20
21	Paint & Supplies			2007	2,657	68	39	68		953	21
22	Paint & Supplies			2007	5,520	142	39	142		1,985	22
23	Wall Paper, Wall Protection			2007	7,306	187	39	187		2,621	23
24	Paint & Supplies			2007	4,746	122	39	122		1,705	24
25	Heating & Cooling Pump			2007	4,214	108	39	108		1,512	25
26	Paint & Supplies			2007	8,833	226	39	226		3,167	26
27	Air Handler			2007	6,160	158	39	158		2,212	27
28	Wall Protection & Corner Guards			2007	7,957	204	39	204		2,856	28
29	Paint & Supplies			2007	4,744	122	39	122		1,705	29
30	Paint & Supplies			2007	5,247	135	39	135		1,887	30
31	Electric Work			2007	5,438	139	39	139		1,949	31
32	A/C			2007	2,534	65	39	65		910	32
33	Paint & Supplies			2007	4,393	113	39	113		1,579	33
34	Paint & Supplies			2007	6,499	167	39	167		2,335	34
35	Lights, Wall Protection, Draperies			2007	27,168	697	39	697		9,755	35
36	Shower Valve			2007	3,650	94	39	94		1,313	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: 1/1/20 Ending: 12/31/20

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	$	$ 1,105	37
38	Electric Work	2007	10,269	263	39	263		3,685	38
39	Wall Covering	2007	3,161	81	39	81		1,134	39
40	Hydraulic Valve	2007	4,207	108	39	108		1,511	40
41	Paint & Supplies	2007	2,065	53	39	53		742	41
42									42
43	Kickplates/Wallcoverings	2008	3,130	80	39	80		1,042	43
44	Kickplates/Wallcoverings	2008	4,179	107	39	107		1,392	44
45	Valve Replacement	2008	3,650	94	39	94		1,219	45
46	Cooling Tower	2008	4,093	105	39	105		1,365	46
47	Water Heater parts replacement	2008	1,516	39	39	39		507	47
48	Water Heater parts replacement	2008	969	25	39	25		324	48
49	Dining Room	2008	3,600	92	39	92		1,198	49
50	Paint/Remodel	2008	2,300	59	39	59		767	50
51	2nd Floor Paint/Remodel	2008	3,000	77	39	77		1,001	51
52	3rd Floor Paint/Remodel	2008	3,500	90	39	90		1,168	52
53	Paint/Remodel	2008	1,500	38	39	38		497	53
54	Remodel - Cabinets/Light Fixtures	2008	600	15	39	15		198	54
55	Remodel - Cabinets/Light Fixtures	2008	1,400	36	39	36		468	55
56	Remodel Supplies	2008	600	15	39	15		198	56
57	Remodel Supplies	2008	252	6	39	6		81	57
58	Remodel Supplies	2008	269	7	39	7		91	58
59	Remodel Supplies	2008	406	10	39	10		133	59
60	Remodel Supplies	2008	663	17	39	17		221	60
61	Remodel Supplies	2008	489	13	39	13		166	61
62	Remodel Supplies	2008	326	8	39	8		106	62
63	Remodel Supplies	2008	465	12	39	12		156	63
64	Remodel Supplies	2008	1,106	28	39	28		366	64
65	Remodel Supplies	2008	1,470	38	39	38		492	65
66	Remodel Supplies	2008	606	16	39	16		205	66
67	Elevator	2008	3,006	77	39	77		1,001	67
68	Elevator	2008	5,538	142	39	142		1,846	68
69	Elevator	2008	4,407	113	39	113		1,469	69
70	TOTAL (lines 4 thru 69)		$ 6,274,338	$ 160,881		$ 160,881	$	$ 2,221,377	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: 1/1/20 Ending: 12/31/20

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	$	$ 2,221,377	1
2	Sprinkler Repairs	2008	537	14	39	14		181	2
3	Sprinkler Repairs	2008	653	17	39	17		219	3
4	Sprinkler Repairs	2008	1,510	39	39	39		505	4
5	Sprinkler Repairs	2008	1,980	51	39	51		662	5
6	Sprinkler Repairs	2008	1,156	30	39	30		388	6
7									7
8	Floor Tile	2009	23,845	611	39	611		7,334	8
9	Remove and Replace Floor Tile	2009	3,000	77	39	77		924	9
10	New Tile in Shower Room	2009	3,000	77	39	77		924	10
11	Install Sheetrock in Shower Room	2009	3,000	77	39	77		924	11
12	Install wood paneling, handrails, corner guards	2009	3,000	77	39	77		924	12
13	Install Doors, Frames, and Glass	2009	14,489	372	39	372		4,462	13
14	New Doors	2009	910	23	39	23		278	14
15	New Doors	2009	1,134	29	39	29		348	15
16	Repair Sinkhole, Repair Pavement, Reseal & Restripe Park	2009	9,625	247	39	247		2,963	16
17	New Faucets and Drains	2009	2,235	57	39	57		686	17
18	New Faucets and Drains	2009	1,290	33	39	33		396	18
19	New Faucets and Drains	2009	1,725	44	39	44		529	19
20	New Faucets and Drains	2009	1,725	44	39	44		529	20
21	New Roofing	2009	68,755	1,763	39	1,763		21,156	21
22	New Roofing	2009	1,950	50	39	50		600	22
23	Install and Paint Over Water Lines	2009	785	20	39	20		240	23
24	Install and Paint Over Water Lines	2009	1,700	44	39	44		526	24
25	Removal of Old Dooring & Installation of Dura Glides	2009	12,315	316	39	316		3,791	25
26	Wall Coverings. Wall Tiles, Table Lamps, Ceiling Pendants	2009	25,004	641	39	641		7,692	26
27									27
28	Drywall & Construction Supplies	2010	1,302	33	39	33		365	28
29	Shower Remodeling, 2nd Floor	2010	3,000	77	39	77		847	29
30	Shower Remodeling, 2nd Floor - Fixing Cracked Tiles	2010	3,000	77	39	77		847	30
31	Replacement Ceiling Tiles	2010	2,750	71	39	71		779	31
32	Replacement Ceiling Tiles, Paint, Fixing Duct	2010	2,410	62	39	62		682	32
33	Cleaners, Paints, Door Hinges, Flooring	2010	1,216	31	39	31		341	33
34	TOTAL (lines 1 thru 33)		$ 6,473,339	$ 165,983		$ 165,983	$	$ 2,282,419	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: 1/1/20 Ending: 12/31/20

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	$ 165,983		$ 165,983	$	$ 2,282,419	1
2	Hardware for Doors/Flooring	2010	1,746	45	39	45		495	2
3	Elevator	2010	153,000	3,923	39	3,923		46,920	3
4	Hinges, Paint, Glass, and Stainless Steel for Basement	2010	6,115	157	39	157		1,727	4
5	Metal Doors Setup	2010	6,175	158	39	158		1,740	5
6	Door Locks	2010	475	12	39	12		132	6
7									7
8	Concrete Work	2011	11,000	282	39	282		4,089	8
9	Concrete & Asphalt Work	2011	6,750	173	39	173		1,730	9
10	Asphalt Work	2011	1,575	40	39	40		401	10
11	Fire Alarm System Devices	2011	8,506	218	39	218		2,180	11
12	HUD Inspection Preparation	2011	5,325	137	39	137		1,369	12
13	Sprinkler Addition in Elevator Pit	2011	2,575	66	39	66		660	13
14	New Hydronic Heater	2011	5,470	140	39	140		1,401	14
15	Chiller Compressor Replacement	2011	10,300	264	39	264		2,640	15
16	Chiller & Cooling Tower Cleaning	2011	7,950	204	39	204		2,040	16
17	New Cooling Tower Fan Motor Pulley & Blower Belts	2011	4,318	111	39	111		1,109	17
18	Kitchen Air Handler	2011	1,245	32	39	32		320	18
19	Sewer Dig Up & Repair	2011	10,500	269	39	269		2,690	19
20	Replaced Broken Pipe& Filled Holes w/ Concrete	2011	5,200	133	39	133		1,331	20
21	Remodel Offices- Ceiling Tiles, Flooring, Lighting, Paint	2011	8,486	218	39	218		2,179	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		27,680	23
24	Remodel Corridors- Lighting, Floor Tile, Ceiling Tile,								24
25	Wallcovering, Handrail, Corner Gauards, Paint Doors	2011	315,993	13,372	39	8,102	(5,270)	86,291	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		28,779	27
28	Remodel PT Room- Lighting, Tile, Paint, Cabinets, Countertops	2011	36,356	932	39	932		9,320	28
29	Elevators- New Flooring, Wall Panels, Wall Base, Ceiling	2011	18,834	483	39	483		4,830	29
30	Specialty Consultation re: Safety Code Surveys	2011	2,905	74	39	74		741	30
31	Develop Fires Saftey Evaluation System	2011	5,278	135	39	135		1,351	31
32	Ceiling Panel	2011	547	14	39	14		140	32
33	Smoke Damper	2011	3,900	100	39	100		1,000	33
34	TOTAL (lines 1 thru 33)		$ 7,334,039	$ 193,323		$ 188,053	$ (5,270)	$ 2,517,703	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: 1/1/20 Ending: 12/31/20

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	$ 193,323		$ 188,053	$ (5,270)	$ 2,517,703	1
2	Insulated Unit	2011	760	19	39	19		192	2
3	Insulated Unit	2011	705	18	39	18		180	3
4	Building Light	2011	710	18	39	18		180	4
5	Metal Door	2011	6,560	168	39	168		1,680	5
6									6
7	Replaced/Reprogrammed Pull Station	2012	2,834	73	39	73		656	7
8	Sprinkler Work	2012	4,925	126	39	126		1,135	8
9	Installed Ductwork necessary for Oxygen Rooms	2012	4,645	119	39	119		1,071	9
10	Metal Doors	2012	1,215	31	39	31		279	10
11	Sales tax on Metal Doors	2012	85	2	39	2		18	11
12	Repair Roof	2012	3,600	92	39	92		829	12
13	Install 28 Smoke Detectors & Fire Alarm System	2012	9,102	233	39	233		2,098	13
14	Credit for Expense Claimed in PY	2012	(110,243)	(2,827)	39	(2,827)		(25,442)	14
15	Replace Cast Iron Pipe	2012	1,400	36	39	36		324	15
16	Mechanical Rooms Repairs	2012	1,100	28	39	28		252	16
17	Basement Bathroom Ventilation	2012	4,000	103	39	103		926	17
18	Repair Heating	2012	3,838	98	39	98		883	18
19	Lever lockset	2012	811	21	39	21		189	19
20	Lever lockset	2012	2,572	66	39	66		594	20
21	Metal Doors	2012	4,450	114	39	114		1,026	21
22	Repair Heating	2012	1,970	51	39	51		458	22
23	New Flooring and walls throughout entire facility	2012	47,836	1,227	39	1,227		11,042	23
24	Misc Repairs to piping in kitchen	2012	3,100	79	39	79		712	24
25	Install Precision Lamps on first floor nurses station	2012	3,551	91	39	91		819	25
26	New Flooring and walls throughout entire facility	2012	50,586	6,297	39	1,297	(5,000)	16,673	26
27	New Flooring and walls throughout entire facility	2012	60,320	6,547	39	1,547	(5,000)	18,922	27
28									28
29	Items deleted in FY10 and before capital rate reconciliation	2012	131,542	3,373	39	3,373		33,852	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,576,013	$ 209,527		$ 194,257	$ (15,270)	$ 2,587,252	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: 1/1/20 Ending: 12/31/20

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	$ 209,527		$ 194,257	$ (15,270)	$ 2,587,252	1
2	Freezer	2013	4,260	109	39	109		818	2
3	Five Star - Parking Lot	2013	8,750	224	39	224		1,681	3
4	Fire Alarm System	2013	13,058	335	39	335		2,512	4
5	Corridors, dining room shades	2013	51,560	1,322	39	1,322		9,915	5
6	Generator	2013	4,708	121	39	121		906	6
7	Floor fixtures 1st & 2nd floor	2013	3,975	102	39	102		765	7
8	Eidco Credit	2013	(50,586)	(1,297)	39	(1,297)		(9,728)	8
9	Sprinkler system	2013	6,299	162	39	162		1,214	9
10	Survey	2013	2,819	72	39	72		541	10
11	Housekeepers store room/bathroom in basement	2013	25,613	657	39	657		4,927	11
12	lighting in dining room	2013	53,560	1,373	39	1,373		10,299	12
13									13
14	Repair walk-in freezer in kitchen	2014	2,015	52	39	52		333	14
15	Install Imperial Water Booster	2014	3,020	77	39	77		469	15
16	New Asphalt on portion of parking lot next to wood fence	2014	850	22	39	22		154	16
17	Cover base/flooring in main hallway	2014	3,679	94	39	94		612	17
18	Remove existing carpet in lobby and replace	2014	3,001	77	39	77		494	18
19	Security Camera system	2014	5,722	147	39	147		918	19
20	Install cabinetry, mirror, lighting, and sinks in beauty shop	2014	4,400	113	39	113		725	20
21	Chller	2014	6,995	179	39	179		1,179	21
22	Booster pump	2014	2,498	64	39	64		411	22
23	Boiler & heater	2014	2,057	53	39	53		334	23
24	Floors in beauty shop	2014	1,718	44	39	44		275	24
25	Supply and Install Cat 5E cables in patient rooms	2014	2,844	73	39	73		511	25
26	Take fire system offline, test system and valves, restore	2014	2,214	57	39	57		347	26
27	Washer	2014	9,900	254	39	254		1,566	27
28	Perform fire services evaluation system test	2014	4,855	124	39	124		849	28
29	Install new flooring and cove base in basement hallways	2014	3,273	84	39	84		581	29
30	Install signage outside of building	2014	6,670	171	39	171		1,202	30
31	Tile flooring in patient bathrooms	2014	3,476	89	39	89		616	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,769,216	$ 214,481		$ 199,211	$ (15,270)	$ 2,622,677	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: 1/1/20 Ending: 12/31/20

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		$ 7,769,216	$ 214,481		$ 199,211	$ (15,270)	$ 2,622,677	1
2	Custom Cabinets & Walls in Rms 101,103, 117	2015	9,000	231	39	231		1,372	2
3	Hot Water Unit	2015	4,485	115	39	115		683	3
4	Fire Sprinkler System Upgrade	2015	4,042	104	39	104		616	4
5	Fire Sprinkler System - New Sprinkler Heads	2015	2,570	66	39	66		392	5
6	Freezer - Evaporator Coil	2015	3,650	94	39	94		557	6
7	Air Conditioner Repair	2015	2,587	66	39	66		393	7
8	Fire Alarm Bell, Smoke Detectors, Power Supply	2015	2,711	70	39	70		414	8
9	Cooler Tower Floatball and Screens	2015	4,233	109	39	109		646	9
10	Cooler Tower R-22 for Compressor	2015	3,080	79	39	79		469	10
11	Cooler Tower Sealing	2015	4,233	109	39	109		646	11
12	Vinyl Plank Flooring	2015	2,650	68	39	68		404	12
13	Cooler Tower Belts and Oiling	2015	2,573	66	39	66		392	13
14	Cooler Tower Algaecide Treatment	2015	3,191	82	39	82		487	14
15	Basement Water Lines	2015	6,800	174	39	174		1,035	15
16	Dishwasher Repiping of Sanitary Line	2015	3,010	77	39	77		458	16
17	Doors in Kitchen	2015	5,338	137	39	137		814	17
18	Low Pressure Water Feeder	2015	2,741	70	39	70		417	18
19									19
20	Repairs and Seal Coating	2016	17,205	441	39	441		2,205	20
21	Fire Alarm System / Repairs	2016	7,818	200	39	200		1,001	21
22	New Cooling Tower	2016	39,996	1,026	39	1,026		5,129	22
23	Repair Freon leak on unit	2016	7,876	202	39	202		1,010	23
24	Paint/Repair 1st floor doors	2016	8,160	209	39	209		1,045	24
25	Install new doors - 3rd floor	2016	11,338	291	39	291		1,454	25
26	Flooring repairs / tiling - 2nd Floor	2016	3,275	84	39	84		420	26
27	Doors - 3rd floor East Stairwell	2016	2,710	69	39	69		346	27
28	Doors - Rooms 232, 316 and 1st Floor Patio	2016	4,498	115	39	115		576	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,938,986	$ 218,834		$ 203,564	$ (15,270)	$ 2,646,057	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: 1/1/20 Ending: 12/31/20

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		$ 7,938,986	$ 218,834		$ 203,564	$ (15,270)	$ 2,646,057	1
2	1st Floor, 2nd Floor, 3rd Floor Doors	2017	4,160	107	39	107		373	2
3	New OEM Boiler Orifices	2017	4,462	114	39	114		400	3
4	Doors for Rm 133,Business Office,Smoking Patio	2017	5,949	153	39	153		534	4
5	New Air Compressor	2017	6,500	167	39	167		583	5
6	Basement Floor Alarm System & 1st floor Annunciator	2017	2,880	74	39	74		259	6
7	Caulk Exterior Windows	2017	4,124	106	39	106		370	7
8	Upgrade to 3rd Floor Bathroom	2017	5,785	148	39	148		519	8
9	New Base Cabinets for Pantry Rooms & Nursing Station	2017	5,800	149	39	149		520	9
10	New Doors for Rooms 233,203,218,3rd Floor Activity Room,330,229	2017	12,383	318	39	318		1,112	10
11	Retube Boiler	2017	19,500	500	39	500		1,750	11
12	Front Entrance Security System	2017	4,195	108	39	108		377	12
13	New Cable for 1st Floor TV	2017	5,989	154	39	154		538	13
14									14
15	New Floor Tile for MDS Office, Social Services Office & Room 118	2018	6,100	156	39	156		391	15
16	New Building Exit Signs	2018	9,400	241	39	241		603	16
17	Replace Main Air Handler Heating Coils	2018	19,919	511	39	511		1,276	17
18	Paint All Rooms on Second Floor	2018	18,050	463	39	463		1,157	18
19	Vacuum & Hydro-Jet double Grease Pit & Lift Station	2018	3,489	89	39	89		224	19
20	Vacuum & Hydro-Jet double Grease Pit & Lift Station	2018	2,911	75	39	75		186	20
21	New Lt Fixtures for !st, 2nd, and 3rd Floor Dining Rooms	2018	7,938	204	39	204		509	21
22	New Door for 2nd Floor Social Services Office								22
23	Ice Machines for 1st and 2nd Floors	2018	3,253	83	39	83		209	23
24	New Kitchen Hot Water Tank	2018	3,087	79	39	79		198	24
25	Paint 1st, 2nd, & 3rd Floor Dinign Rooms	2018	13,187	338	39	338		845	25
26	Replace Two Relays on Chiller	2018	2,684	69	39	69		172	26
27	Install New Circuit Breaker to Compressor 3	2018	3,663	94	39	94		235	27
28	Remove and Re-tile Tile Around Shower Base Wall	2018	4,840	124	39	124		310	28
29	Install New Door Hinges for Rooms 202,204,208,211,302,333	2018	3,460	89	39	89		221	29
30	Central Supply, Housekeepiong Office								30
31	Cubcle Curtains	2018	11,324	290	39	290		726	31
32									32
33									33
34	**TOTAL (lines 1 thru 33)**		$ 8,134,018	$ 223,835		$ 208,565	$ (15,270)	$ 2,660,656	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: 1/1/20 Ending: 12/31/20

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 12G, Carried Forward		$ 8,134,018	$ 223,835		$ 208,565	$ (15,270)	$ 2,660,656	1
2	Install New RP2 Black Flow Cold Water for Janitor Closet & Hot	2019	4,730	156	39	156		312	2
3	New Ejector Pump System	2019	13,886	391	39	391		782	3
4	Install Direct TV in Building	2019	8,760	259	39	259		519	4
5	Install New Cirtcuits in 1st Floor Dining Room, 2nd Floor Dining	2019	6,000	189	39	189		377	5
6	Replace Exhaust Fan on Heating System	2019	4,259	144	39	144		288	6
7	Replace 2 Time Clos Controlling Circuits of Exterior Lighting	2019	3,625	93	39	93		186	7
8	New Hopper	2019	3,688	95	39	95		181	8
9	Install New Radiator	2019	4,095	105	39	105		193	9
10	Building Interior Painting Project (1st Billing)	2019	4,550	117	39	117		204	10
11	Building Interior Painting Project (2nd Billing)	2019	4,060	104	39	104		182	11
12	Sealcoat, Crack fill & Stripe Parking Lot (Down Payment)	2019	5,139	132	39	132		231	12
13	Building Interior Painting Project (3rd Billing)	2019	3,500	90	39	90		150	13
14	Building Interior Painting Project (4th Billing)	2019	4,060	104	39	104		174	14
15	Building Interior Painting Project (5th Billing)	2019	4,060	104	39	104		174	15
16	New Initiating Device Circuit Module for Alarm System	2019	2,448	63	39	63		105	16
17	Building Interior Painting Project (6th Billing)	2019	4,060	104	39	104		174	17
18	Security Doors & Alarm Installation	2019	3,166	81	39	81		135	18
19	Building Interior Painting Project (7th Billing)	2019	3,500	90	39	90		142	19
20	Replace Fence in Front of Building	2019	6,095	156	39	156		247	20
21	Sealcoat, Crack, Fill & Stripe Parking Lot (2nd Payment)	2019	5,139	132	39	132		209	21
22	Remove Tile & Seal Opening Inside Wall on 2nd Floor Showers	2019	4,866	125	39	125		198	22
23	Tamper Panel Replacement on Fire Alarm System	2019	3,620	93	39	93		139	23
24	Replace All Boiler Isolation Valves	2019	4,108	105	39	105		149	24
25	2 New Hot Water Heaters	2019	78,750	2,019	39	2,019		2,692	25
26	Install New Cabling for IT	2019	8,290	213	39	213		283	26
27	Medical Shower Filters and Water Testing	2019	3,726	96	39	96		119	27
28	Install New Automatic Transfer Switchfor Generator	2019	7,879	202	39	202		253	28
29	Add New Electrical Outlets in 3rd Floor Therapy Room, Room 22	2019	2,600	67	39	67		83	29
30	Replace Pressure Reducing Valves on Domestic Water System	2019	6,900	177	39	177		206	30
31	Install New Electric Unit Heater for the Generator Room	2019	3,400	87	39	87		102	31
32	New Kitchen/Laundry Hot Water Boiler & 2 Fully Insulated 120 (	2019	38,500	987	39	987		1,069	32
33	New Return Pump for Domestic Hot Water	2019	2,529	65	39	65		70	33
34	TOTAL (lines 1 thru 33)		$ 8,398,005	$ 230,778		$ 215,508	$ (15,270)	$ 2,670,983	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: 1/1/20 Ending: 12/31/20

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 12H, Carried Forward		$ 8,398,005	$ 230,778		$ 215,508	$ (15,270)	$ 2,670,983	1
2									2
3	Install New Valve in Elevator #2	2020	5,800	149	39	136	(12)	149	3
4	Repair, Patch, Skim Coat, Replace Moldy Drywall in Rooms 123,	2020	2,355	60	39	55	(5)	60	4
5	Repair, Patch, Sand, Paint 1st floor East Corridor Rooms	2020	2,495	64	39	53	(11)	64	5
6	Repair Walls, Patch, Skimcoat & Paint Rooms and Bathrooms on	2020	2,495	64	39	53	(11)	64	6
7	Replace Belts, Motors, Lubricate Roof Exhaust Fans	2020	2,537	65	39	54	(11)	65	7
8	New Convector fro Room 106	2020	4,500	115	39	96	(19)	115	8
9	Repair, Patch & Paint 1st Floor Center Corridor Rooms, Bathroo	2020	3,900	100	39	83	(17)	100	9
10	New Fire Alarm System	2020	7,584	194	39	146	(49)	194	10
11	Insulate Cold Water Feed and Domestic Hot Water Boiler Systems	2020	2,975	76	39	44	(32)	76	11
12	Replace Jockey Pump on Sprinkler System	2020	2,750	71	39	29	(41)	71	12
13	Replace Leaking Section of Cast Iron Drain on 1st Floor	2020	2,850	73	39	30	(43)	73	13
14	Winterize Cooling Tower	2020	2,980	76	39	19	(57)	76	14
15	New Fence With Walk Gates & Dead Bolt Locks	2020	17,550	450	39	75	(375)	450	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)		$ 8,458,777	$ 232,336		$ 216,384	$ (15,952)	$ 2,672,541	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: 1/1/20 Ending: 12/31/20

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	$ 77,763	$ 127,200	$ 49,437	5	$ 710,506	71
72	Current Year Purchases	13,792	13,792	1,379	(12,413)	5	13,792	72
73	Fully Depreciated Assets	1,005,911					1,005,911	73
74								74
75	TOTALS	$ 1,655,703	$ 91,555	$ 128,579	$ 37,024		$ 1,730,209	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)	$ 11,314,480	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 323,891	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 344,963	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 21,072	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,402,750	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: 1/1/20 Ending: 12/31/20

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2021	$
13.	/2022	$
14.	/2023	$

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: 1/1/20 Ending: 12/31/20

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.)

		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	$	4,346	$ 297,237	$	4,346	$ 297,237	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		1,882	148,153		1,882	148,153	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		3,845	300,018		3,845	300,018	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				73,531		73,531	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): X-Ray	39-2					6,189		6,189	12
13	Other (specify): Lab	39-2					3,857		3,857	13
14	TOTAL			$	10,073	$ 745,407	$ 83,577	10,073	$ 828,984	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: 1/1/20 Ending: 12/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/20 (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	$ (312,171)	$ (154,645)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	17,120,458	17,120,458	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	744,232	744,232	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		360,351	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 17,552,519	$ 18,070,396	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	2,462,774	2,462,774	15
16	Equipment, at Historical Cost	1,034,972	1,670,972	16
17	Accumulated Depreciation (book methods)	(1,570,891)	(4,387,214)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	40,913	214,266	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(25,003)	(136,992)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	157,116	157,116	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,099,881	$ 7,176,922	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 19,652,400	$ 25,247,318	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 6,570,773	$ 7,114,652	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	53,884	53,884	28
29	Short-Term Notes Payable		489,015	29
30	Accrued Salaries Payable	398,395	398,395	30
31	Accrued Taxes Payable (excluding real estate taxes)	39,670	39,670	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 7,062,722	$ 8,095,616	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		17,182,050	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)**	$	$ 17,182,050	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,062,722	$ 25,277,666	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 12,589,678	$ (30,348)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 19,652,400	$ 25,247,318	48

*(See instructions.)

Facility Name & ID Number Belhaven Nursing Rehab Ctr # 0048215 Report Period Beginning: 1/1/20 Ending: 12/31/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 10,522,224	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 10,522,224	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,067,452	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Rounding Error**	2	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 2,067,454	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)**	$ 12,589,678	24 *

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

Facility Name & ID Number Belhaven Nursing Rehab Ctr # 0048215 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	$ 14,889,383	1
2	Discounts and Allowances for all Levels	81,637	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 14,971,020	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	236,356	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 236,356	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	2,294,279	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	2,937	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	79,649	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,376,865	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	14,988	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 14,988	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Misc Income	9,144	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 9,144	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 17,608,373	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,646,559	31
32	Health Care	6,782,175	32
33	General Administration	4,840,646	33
	B. Capital Expense		
34	Ownership	439,533	34
	C. Ancillary Expense		
35	Special Cost Centers	832,008	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 15,540,921	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,067,452	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,067,452	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 12,089,120	44
45	Private Pay - Net Inpatient Revenue	72,955	45
46	Medicare - Net Inpatient Revenue	2,247,831	46
47	Other-(specify)	561,115	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 14,971,021	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	2,002	2,137	$ 113,767	$ 53.24	1
2	Assistant Director of Nursing	6,479	6,946	292,576	42.12	2
3	Registered Nurses	11,027	12,241	490,870	40.10	3
4	Licensed Practical Nurses	42,129	57,704	2,162,814	37.48	4
5	CNAs & Orderlies	85,568	108,640	1,927,500	17.74	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	9,829	10,941	192,400	17.59	10
11	Social Service Workers	5,516	5,988	145,827	24.35	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	25,638	28,909	491,156	16.99	15
16	Dishwashers					16
17	Maintenance Workers	4,852	5,239	109,305	20.86	17
18	Housekeepers	38,698	44,211	726,099	16.42	18
19	Laundry	5,419	6,612	124,643	18.85	19
20	Administrator	2,040	2,080	131,110	63.03	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,290	11,580	227,709	19.66	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,293	5,024	170,596	33.96	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	253,780	308,252	$ 7,306,372 *	$ 23.70	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	405	$ 19,424	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	944	50,417	10-3	38
39	Pharmacist Consultant	352	17,595	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	58	3,786	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,759	$ 91,222		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	268	2,723	10-2	52
53	TOTAL (lines 50 - 52)	268	$ 2,723		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Birn, Philip	Administrator	0	$ 131,110
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 131,110

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
Ashman and Stein	Legal	$ 24,631
Fuchs and Roselli	Legal	13,747
Global Recovery Services	Legal	4,088
Infinity Funding sedgewick	Legal	285,473
Infinity Healthcare Management	Legal	392
Klauke Law Group	Legal	26
Mcguire Woods	Legal	2,099
Polsinelli PC	Legal	11,738
See attached schedule		813,005
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 1,155,199

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 122,866
Unemployment Compensation Insurance	34,233
FICA Taxes	600,774
Employee Health Insurance	211,798
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension Expense	14,159
Uniforms	8,599
Employee backround checks	1,304
Other Emplyee Benefits	12,769
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,006,502

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	$ 1,768
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
City of Chicago	2,465
Clia Labarotory	180
Other Licence and due	1,085
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,498

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
Travel Reimbursement	10
In-State Travel	
Travel Reimbursement	13,706
Travel Reimbursement	12,211
Seminar Expense	
Education and Seminars	7,370
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 33,297

* Attach copy of IMRF notifications

**See instructions.

C. Professional Services

Vendor/Payee	Type	Amount
GGM	Accounting Fees	3,300
Goldburg and Johnson	Accounting Fees	3,000
Elevate Energy	Professional fees	550
Empire Risk Management Services, I	Professional fees	12,000
Genex Services, LLC.	Professional fees	26
GGM Associates, INC. - 2019	Professional fees	2,700
Global Fiscal Midwest LLC	Professional fees	11,578
Infinity H Funding	Professional fees	423
Infinity Healthcare Management of I	Professional fees	916
LIFE SAFETY RESOURCES, LLC	Professional fees	3,284
MTS Consulting	Professional fees	1,608
PROSPECT RESOURCES	Professional fees	1,350
Stout Risius Ross LLC - 4042592	Professional fees	5,706
USA Risk Management Inc	Professional fees	1,357
Premier Destine INC	Professional fees	705
Infinity Healthcare Management of I	Professional fees	764,502
See attached schedule		813,005

Facility Name & ID Number Belhaven Nursing Rehab Ctr # 0048215 Report Period Beginning: 1/1/20 Ending: 12/31/20

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? _____ 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 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **185,425** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **467,458**
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.