

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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

I. IDPH License ID Number: 0050088

Facility Name: NILES NRSG & REHAB CTR

Address: 9777 GREENWOOD AVE NILES 60714
Number City Zip Code

County: COOK

Telephone Number: (847) 470-0000 Fax # (847) 967-5462

HFS ID Number:

Date of Initial License for Current Owners: 6/20/08

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

In the event there are further questions about this report, please contact:
Name: Alan Sorscher Telephone Number: 708-449-1900
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/12 to 12/31/12 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)
(Type or Print Name) Alan Sorscher
(Title) CFO

Paid Preparer

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

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number NILES NRSG & REHAB CTR# 0050088 Report Period Beginning: 1/1/12 Ending: 12/31/12

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 bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>152</u>	Skilled (SNF)	<u>152</u>	<u>55,632</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>152</u>	Intermediate (ICF)	<u>152</u>	<u>55,632</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>304</u>	TOTALS	<u>304</u>	<u>111,264</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>44,787</u>	<u>1,197</u>	<u>3,514</u>	<u>49,498</u>	8
9	SNF/PED					9
10	ICF	<u>44,787</u>	<u>1,196</u>	<u>3,514</u>	<u>49,497</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>89,574</u>	<u>2,393</u>	<u>7,028</u>	<u>98,995</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 88.97%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census?

YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 6/20/08

J. Was the facility purchased or leased after January 1, 1978?

YES ☒Date 6/20/08NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐If YES, enter number
of beds certified 304 and days of care provided 6,949Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/12Fiscal Year: 12/31/12

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

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	520,152	65,958	15,000	601,110		601,110	(3,208)	597,902			1
2	Food Purchase		561,598		561,598		561,598	(298)	561,300			2
3	Housekeeping	362,553	66,953		429,506		429,506		429,506			3
4	Laundry	115,943	49,188		165,131		165,131		165,131			4
5	Heat and Other Utilities			369,585	369,585		369,585	758	370,343			5
6	Maintenance	93,785	36,266	98,805	228,856		228,856	(6,990)	221,866			6
7	Other (specify):*											7
8	TOTAL General Services	1,092,433	779,963	483,390	2,355,786		2,355,786	(9,738)	2,346,048			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	5,033,055	494,975	25,200	5,553,230		5,553,230	21,574	5,574,804			10
10a	Therapy			697,678	697,678		697,678		697,678			10a
11	Activities	311,070	49,839		360,909		360,909		360,909			11
12	Social Services	178,952		13,541	192,493		192,493		192,493			12
13	CNA Training											13
14	Program Transportation			680	680		680		680			14
15	Other (specify):* Pharmacy Consultant			29,061	29,061		29,061		29,061			15
16	TOTAL Health Care and Programs	5,523,077	544,814	790,160	6,858,051		6,858,051	21,574	6,879,625			16
	C. General Administration											
17	Administrative	97,040			97,040		97,040		97,040			17
18	Directors Fees											18
19	Professional Services			383,789	383,789		383,789	(265,895)	117,894			19
20	Dues, Fees, Subscriptions & Promotions			22,855	22,855		22,855		22,855			20
21	Clerical & General Office Expenses	323,971	135,743	28,506	488,220		488,220	49,437	537,657			21
22	Employee Benefits & Payroll Taxes			1,103,213	1,103,213		1,103,213	88,933	1,192,146			22
23	Inservice Training & Education											23
24	Travel and Seminar			33,070	33,070		33,070	(4,290)	28,780			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			155,833	155,833		155,833	26,706	182,539			26
27	Other (specify):*											27
28	TOTAL General Administration	421,011	135,743	1,727,266	2,284,020		2,284,020	(105,109)	2,178,911			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,036,521	1,460,520	3,000,816	11,497,857		11,497,857	(93,273)	11,404,584			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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			239,452	239,452		239,452	89,700	329,152			30
31	Amortization of Pre-Op. & Org.							504,224	504,224			31
32	Interest			131,873	131,873		131,873	484,289	616,162			32
33	Real Estate Taxes							754,482	754,482			33
34	Rent-Facility & Grounds			2,280,000	2,280,000		2,280,000	(1,599,528)	680,472			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			2,651,325	2,651,325		2,651,325	233,167	2,884,492			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		295,404		295,404		295,404		295,404			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			1,001,746	1,001,746		1,001,746		1,001,746			42
43	Other (specify):* Bad Debt			460,000	460,000		460,000	(460,000)				43
44	TOTAL Special Cost Centers		295,404	1,461,746	1,757,150		1,757,150	(460,000)	1,297,150			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,036,521	1,755,924	7,113,887	15,906,332		15,906,332	(320,106)	15,586,226			45

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(25,264)	30		9
10	Interest and Other Investment Income	(4,925)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(67)	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	(7,310)	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	(460,000)	43		24
25	Fund Raising, Advertising and Promotional	(33,704)	21		25
	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	(19,733)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (551,003)		\$	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	2	
		Amount	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)	230,897	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 230,897		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (320,106)		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	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44						44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

STATE OF ILLINOIS
NILES NRSG & REHAB CTR

ID# 0050088
Report Period Beginning: 1/1/12
Ending: 12/31/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending Income	\$ (2,350)	6	1
2	Miscellaneous Revenue	(17,383)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(19,733)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number NILES NRSRG & REHAB CTR # 0050088 Report Period Beginning: 1/1/12 Ending: 12/31/12

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(67)	(3,141)	0	0	0	0	0	0	0	0	0	(3,208)	1
2	Food Purchase	0	(298)	0	0	0	0	0	0	0	0	0	(298)	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	758	0	0	0	0	0	0	0	0	0	758	5
6	Maintenance	(2,350)	(4,640)	0	0	0	0	0	0	0	0	0	(6,990)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,417)	(7,321)	0	0	0	0	0	0	0	0	0	(9,738)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	21,574	0	0	0	0	0	0	0	0	0	21,574	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	21,574	0	0	0	0	0	0	0	0	0	21,574	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	(304,740)	38,845	0	0	0	0	0	0	0	0	(265,895)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(58,397)	72,354	35,480	0	0	0	0	0	0	0	0	49,437	21
22	Employee Benefits & Payroll Taxes	0	88,933	0	0	0	0	0	0	0	0	0	88,933	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	(4,290)	0	0	0	0	0	0	0	0	0	(4,290)	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	26,706	0	0	0	0	0	0	0	0	0	26,706	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(58,397)	(121,037)	74,325	0	0	0	0	0	0	0	0	(105,109)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(60,814)	(106,784)	74,325	0	0	0	0	0	0	0	0	(93,273)	29

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(25,264)	0	114,964	0	0	0	0	0	0	0	0	89,700	30
31	Amortization of Pre-Op. & Org.	0	0	504,224	0	0	0	0	0	0	0	0	504,224	31
32	Interest	(4,925)	0	489,214	0	0	0	0	0	0	0	0	484,289	32
33	Real Estate Taxes	0	0	754,482	0	0	0	0	0	0	0	0	754,482	33
34	Rent-Facility & Grounds	0	(1,599,528)	0	0	0	0	0	0	0	0	0	(1,599,528)	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	(30,189)	(1,599,528)	1,862,884	0	0	0	0	0	0	0	0	233,167	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(460,000)	0	0	0	0	0	0	0	0	0	0	(460,000)	43
44	TOTAL Special Cost Centers	(460,000)	0	0	0	0	0	0	0	0	0	0	(460,000)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(551,003)	(1,706,312)	1,937,209	0	0	0	0	0	0	0	0	(320,106)	45

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	40			Infinity Healthcare	Hillside	Management Co
Moishe Gubin	40					
A&F General Partnership	20					

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)	
1	V	1	DIEATRY	\$ 15,000	INFINITY HEALTHCARE MANAGEMENT	46.25%	\$ 11,859	\$ (3,141)	1
2	V	2	RAW FOOD	298	INFINITY HEALTHCARE MANAGEMENT			(298)	2
3	V	5	UTILITIES		INFINITY HEALTHCARE MANAGEMENT		758	758	3
4	V	6	MAINTENANCE	9,425	INFINITY HEALTHCARE MANAGEMENT		4,785	(4,640)	4
5	V	10	NURSING	25,200	INFINITY HEALTHCARE MANAGEMENT		46,774	21,574	5
6	V	19	PROFESSIONAL FEES	306,000	INFINITY HEALTHCARE MANAGEMENT		1,260	(304,740)	6
7	V	21	OFFICE EXPENSE	34,142	INFINITY HEALTHCARE MANAGEMENT		106,496	72,354	7
8	V	22	LIFE INSURANCE		INFINITY HEALTHCARE MANAGEMENT		88,933	88,933	8
9	V	24	TRAVEL	4,600	INFINITY HEALTHCARE MANAGEMENT		310	(4,290)	9
10	V	26	LIABILITY INSURANCE		INFINITY HEALTHCARE MANAGEMENT		515	515	10
11	V	34	RENT		INFINITY HEALTHCARE MANAGEMENT		7,944	7,944	11
12	V	34	RENT	2,677,000	NILES NURSING REALTY		1,069,528	(1,607,472)	12
13	V	26	PROPERTY INSURANCE		NILES NURSING REALTY		26,191	26,191	13
14	Total			\$ 3,071,665			\$ 1,365,353	\$ * (1,706,312)	14

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

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		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	31	Amortization	\$	NILES NURSING REALTY		\$ 504,224	\$ 504,224	15
16	V	21	Office Expense		NILES NURSING REALTY		35,480	35,480	16
17	V	30	Depreciation		NILES NURSING REALTY		114,769	114,769	17
18	V	32	Interest	3,314	NILES NURSING REALTY		492,528	489,214	18
19	V	19	Professional Fees		NILES NURSING REALTY		38,845	38,845	19
20	V	33	Taxes		NILES NURSING REALTY		754,482	754,482	20
21	V	30	Depreciation		INFINITY HEALTHCARE MANAGEMENT		195	195	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			\$ 3,314			\$ 1,940,523	\$ * 1,937,209	39

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

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

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	Capital One Bank		x	Mortgage	\$101,325.00		\$ 16,500,000	\$ 16,425,126	8/21/17	5.5000	\$ 362,528	1							
2	Spa		x	Mortgage	Interest Only		6,500,000	6,500,000	Various	10.0000	130,000	2							
3												3							
4												4							
5												5							
	Working Capital																		
6	Bank Leumi USA		x	Working Capital	None	7/18/08	3,000,000		7/16/12	Variable	52,694	6							
7	Capital One Bank		x	Working Capital	None	8/31/12	2,511,541	2,511,541	8/31/15	Variable	44,710	7							
8	Infinity Funding	x		Working Capital	None	Various	700,000	700,000	Various	Various	34,469	8							
9	TOTAL Facility Related				\$101,325.00		\$ 29,211,541	\$ 26,136,667			\$ 624,401	9							
	B. Non-Facility Related*																		
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 29,211,541	\$ 26,136,667			\$ 624,401	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

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.			
1. Real Estate Tax accrual used on 2011 report.		\$	(111,799)	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.)		\$	621,420	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	733,219	3	
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	21,263	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.		\$	754,482	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007	567,970	8	
		2008	581,250	9	
		2009	668,938	10	
		2010	613,791	11	
		2011	621,420	12	
				13	FOR BHF USE ONLY
				13	FROM R. E. TAX STATEMENT FOR 2011 \$ 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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME
NILES NRSG & REHAB CTR

COUNTY
COOK

FACILITY IDPH LICENSE NUMBER
0050088

CONTACT PERSON REGARDING THIS REPORT
Alan Sorscher

TELEPHONE
(708) 449-1900
FAX #
(
)

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1. 09-11-306-005-0000	NURSING FACILITY	\$ 243,190.31	\$ 243,190.31
2. 09-11-306-006-0000	NURSING FACILITY	\$ 243,108.52	\$ 243,108.52
3. 09-11-306-013-0000	NURSING FACILITY	\$ 135,121.29	\$ 135,121.29
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 621,420.12	\$ 621,420.12

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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: N/A

B. General Construction Type: Exterior Concrete Frame Steel

Number of Stories 6

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (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

☒ (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?

☒ YES

☐ NO

If so, please complete the following:

1. Total Amount Incurred: 18,185,064

2. Number of Years Over Which it is Being Amortized: 15

3. Current Period Amortization: 504,224

4. Dates Incurred: Prior to 8/31/12

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	Nursing Home		2012	\$ 500,000	1
2					2
3	TOTALS			\$ 500,000	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	304		2012		\$ 6,000,000	\$ 64,103	39	\$ 153,846	\$ 89,743	\$ 64,103
5										
6										
7										
8										
	Improvement Type**									
9	Signs		2008		271	7	39	7		35
10	Signs		2008		8,184	210	39	210		1,049
11	Sprinkler Installation		2008		2,305	59	39	59		295
12	Fire Alarm Repairs		2008		1,701	44	39	44		218
13	Install Sign		2008		8,315	213	39	213		1,066
14	Prep Work for Sign Install		2008		2,800	72	39	72		359
15	Smoke Damper		2008		2,150	55	39	55		276
16	Boiler Pump Maintenance		2008		1,106	28	39	28		141
17	A/C - Water Chiller		2008		1,164	30	39	30		149
18	A/C - Unit Repair		2008		970	25	39	25		124
19	Fire Dampers		2008		5,543	142	39	142		711
20	Fixed Boiler for Hot Water		2008		1,348	35	39	35		173
21	A/C Compressor		2008		12,764	327	39	327		1,636
22	Freezer Repairs		2008		980	25	39	25		126
23	New Motor for Heater, Fix Pump, Boiler		2008		5,493	141	39	141		704
24	Hot Water Heater Repairs		2008		908	23	39	23		116
25	Freezer Repairs		2008		1,030	26	39	26		132
26	Dish Installation - Cable		2008		9,000	231	39	231		1,154
27	Cleared Short - Elevator		2008		754	19	39	19		96
28	Replaced Shorting Bar		2008		347	9	39	9		45
29	New Button for Elevator		2008		618	16	39	16		79
30	New Relay for Elevator		2008		300	8	39	8		39
31	New Door Contractor for Elevator		2008		685	18	39	18		88
32	New Contractors/Relays for Elevator		2008		1,157	30	39	30		149
33	Elevator Hydraulic Packing		2008		1,400	36	39	36		180
34	Elevator Hydraulic Oil, Seals, Rings		2008		5,190	133	39	133		665
35	Laundry Room Door Installation		2008		1,430	37	39	37		184
36	3rd Floor Exit Door		2008		1,323	34	39	34		153

*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

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	Stop Strip for Door	2008	\$ 774	\$ 20	39	\$ 20	\$	\$ 99	37
38	Door Replacement Parts	2008	940	24	39	24		120	38
39	Door Alarm Systems	2008	2,067	53	39	53		265	39
40	Door Control Service Electric Work	2008	828	21	39	21		106	40
41	Painting 2nd Floor	2009	4,250	109	39	109		436	41
42	Painting 2nd Floor	2009	3,700	95	39	95		380	42
43	Paint Doors	2009	800	21	39	21		83	43
44	Remodeling/Painting Supplies	2009	455	12	39	12		47	44
45	Painting	2009	3,500	90	39	90		359	45
46	Painting	2009	3,500	90	39	90		359	46
47	Painting	2009	3,900	100	39	100		400	47
48	Painting	2009	3,500	90	39	90		359	48
49	Painting	2009	3,900	100	39	100		400	49
50	Floor Tiles	2009	5,904	151	39	151		605	50
51	Kitchen Doors	2009	1,500	38	39	38		153	51
52	Removate Hallways	2009	6,000	154	39	154		616	52
53	Renovate Lobby Floors	2009	4,060	104	39	104		416	53
54									54
55	Fire Protection Sprinler Work	2009	45,518	1,167	39	1,167		4,668	55
56	Fire Protection Sprinler Work	2009	59,483	1,525	39	1,525		6,101	56
57	Install Exhaust Fan	2009	500	13	39	13		51	57
58	Relocate Drain Pipes	2009	2,525	65	39	65		259	58
59	Install Wiring & Pipes	2009	1,350	35	39	35		139	59
60	Install Wiring	2009	1,585	41	39	41		163	60
61	Install Windows	2009	1,300	33	39	33		133	61
62	Remove and Install New A/C	2009	38,840	996	39	996		3,984	62
63	A/C Installation	2009	2,392	61	39	61		245	63
64	A/C Installation	2009	2,200	56	39	56		225	64
65	Install Floor Tiles	2009	7,200	185	39	185		739	65
66	Furnishing of Signage	2009	2,218	57	39	57		228	66
67	Fire Sprinkler	2009	1,445	37	39	37		148	67
68	Painting	2009	3,500	90	39	90		359	68
69	Install Extra Insulation	2010	1,105	28	39	28		85	69
70	TOTAL (lines 4 thru 69)		\$ 6,299,975	\$ 71,795		\$ 161,538	\$ 89,743	\$ 96,973	70

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

Facility Name & ID Number NILES NRSNG & REHAB CTR

0050088

Report Period Beginning:

1/1/12

Ending:

12/31/12

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		\$ 6,299,975	\$ 71,795		\$ 161,538	\$ 89,743	\$ 96,973	1
2	Remove and Replaced Existing Carpet Tile	2010	573	15	39	15		44	2
3	Grain Quarry Tile Materials and Freight	2010	797	20	39	20		61	3
4	Paint Nursing Station and Baseboards	2010	830	21	39	21		64	4
5	Freeyer Floor and Dishwasher Sink	2010	530	14	39	14		41	5
6	Patched/Painted Walls, Handrails, Double Doors	2010	3,200	82	39	82		246	6
7	Granite and Paint Supplies	2010	710	18	39	18		54	7
8	Painting on 3rd and 4th Floor	2010	1,635	42	39	42		126	8
9	Marble Tile and Labor	2010	1,000	26	39	26		77	9
10	Install Toilet Bowls	2010	327	8	39	8		25	10
11	Install Toilet Bowls	2010	327	8	39	8		25	11
12	Removed and Installed New Carpet	2010	1,500	38	39	38		115	12
13	Install New Kitchen Tiles	2010	1,174	30	39	30		90	13
14	Tuckpointing	2010	2,215	57	39	57		171	14
15	Paint	2010	1,887	48	39	48		145	15
16	Paint and Semi-Gloss	2010	661	17	39	17		51	16
17	Paint	2010	661	17	39	17		51	17
18	Paint and Primer	2010	818	21	39	21		63	18
19	Paint	2010	758	19	39	19		58	19
20	Painting & Wallpapering	2010	1,556	40	39	40		120	20
21	Replaced Compressor and Labor	2010	9,500	244	39	244		731	21
22	Install New High Pressure Sodium Light Fixture	2010	880	23	39	23		68	22
23	New Venolation Air Handler	2010	1,050	27	39	27		81	23
24	Repair & Replace Hot Gas Line	2010	6,050	155	39	155		465	24
25	Repair & Repave Sidewalks & Parking Lot	2010	30,390	779	39	779		2,337	25
26	Install New Showers and & Water system	2011	154,527	3,962	39	2,750	(1,212)	7,924	26
27	Replace Lighting	2011	1,185	30	39	30		60	27
28	Repair Main Electrical Distribution Box, Install New Outlets & Sw	2011	8,950	229	39	229		458	28
29	Fix Small Steamer and Mount Wire & Install Circulating A/C Pun	2011	4,230	108	39	108		216	29
30	Replace Compressor on Air Conditioning Chiller	2011	11,624	298	39	298		596	30
31	Replace Ignition Control On Boilers	2011	1,103	28	39	28		56	31
32	Repair & Seal Power Line Shaft & Remove Rust and Reapir Wall	2011	5,750	147	39	147		294	32
33	Modernize Two 5 Stop Passenger Elevators	2011	143,386	3,677	39	3,677		7,354	33
34	TOTAL (lines 1 thru 33)		\$ 6,699,759	\$ 82,046		\$ 170,577	\$ 88,531	\$ 119,243	34

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

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		\$ 6,699,759	\$ 82,046		\$ 170,577	\$ 88,531	\$ 119,243	1
2									2
3									3
4	Page Not Used								4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12	Replace hot water risers, shower drains, p-traps								12
13	Fire alarm system install								13
14	Fire alarm system install								14
15	Install sink drain 7 p-trap, patch floor								15
16	Vinyl plank flooring								16
17	Ceiling panels, padlocks, screws, motor & condensor wheels								17
18	TV remotes, batteries, powerstrips, cable								18
19	Vinyl cve base, outlet grounded powerstrip								19
20	Vinyl cve base case								20
21	Install sink drains w grades & p-trap, patch floor								21
22									22
23	Repair, sand, prime, & paint walls, install new tiles								23
24	Repair, sand, prime, & paint walls, install new tiles								24
25	Repair, sand, prime, & paint walls, install new tiles								25
26	Remove wall paper & molds, install tiles, repair & paint walls								26
27	Remove wall paper & molds, repair & paint walls								27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,699,759	\$ 82,046		\$ 170,577	\$ 88,531	\$ 119,243	34

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

Facility Name & ID Number NILES NRSRG & REHAB CTR

0050088

Report Period Beginning:

1/1/12

Ending:

12/31/12

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		\$ 6,699,759	\$ 82,046		\$ 170,577	\$ 88,531	\$ 119,243	1
2	Modernize Two 5 Stop Passenger Elevators	2011	104,672	2,684	39	2,684		5,368	2
3	Paint & Materials for First Floor Renevations	2011	654	17	39	17		34	3
4	Install New Tile, Sand & Paint Walls, Replace Plumbing	2011	3,850	99	39	99		198	4
5	Install New Floor, Move Electrical Outlers, Install Chair Rail	2011	6,280	161	39	161		322	5
6	Install Sprinkler Heads in Laundry Room	2011	925	24	39	24		48	6
7	Recharge Antifreeze System/Change OS&Y Valve	2011	2,998	77	39	77		154	7
8	Retrofit Lights	2011	40,064	1,027	39	1,027		2,054	8
9	Recharge Antifreeze System, Refill Freon, Repair A/C	2011	34,518	885	39	885		1,770	9
10	Replace Doors & Locks	2011	517	13	39	13		26	10
11									11
12	Replace hot water risers, shower drains, p-traps	2012	6,000	154	39	26	(128)	154	12
13	Fire alarn system install	2012	3,000	77	39	71	(6)	77	13
14	Fire alarn system install	2012	2,800	72	39	36	(36)	72	14
15	Install sink drain 7 p-trap, patch floor	2012	2,200	56	39	33	(23)	56	15
16	Vinyl plank flooring	2012	3,086	79	39	13	(66)	79	16
17	Ceiling panels, padlocks, screws, motor & condensor wheels	2012	3,051	78	39	39	(39)	78	17
18	TV remotes, batteries, powerstrips, cable	2012	1,118	29	39	12	(17)	29	18
19	Vinyl cve base, outlet grounded powerstrip	2012	528	14	39	5	(9)	14	19
20	Vinyl cve base case	2012	349	9	39	3	(6)	9	20
21	Install sink drains w grades & p-trap, patch floor	2012	2,200	56	39	5	(51)	56	21
22		2012	1,098	28	39	12	(16)	28	22
23	Repair, sand, prime, & paint walls, install new tiles	2012	860	22	39	18	(4)	22	23
24	Repair, sand, prime, & paint walls, install new tiles	2012	860	22	39	18	(4)	22	24
25	Remove wall paper & molds, install tiles, repair & paint walls	2012	970	25	39	15	(10)	25	25
26	Remove wall paper & molds, repair & paint walls	2012	540	14	39	8	(6)	14	26
27	Paint, prime, sand	2012	540	14	39	8	(6)	14	27
28	Install wooden fence	2012	400	10	39	6	(4)	10	28
29	Paint wall	2012	270	7	39	4	(3)	7	29
30	Install exhaust fans & grills	2012	450	12	39	6	(6)	12	30
31	Remove molds, paint walls, install exhaust fans	2012	500	13	39	6	(7)	13	31
32	Compressor installation	2012	600	15	39	8	(7)	15	32
33	Replace core, dryer, refrigerant	2012	841	22	39	11	(11)	22	33
34	TOTAL (lines 1 thru 33)		\$ 6,926,497	\$ 87,859		\$ 175,926	\$ 88,067	\$ 130,043	34

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

Facility Name & ID Number NILES NRSNG & REHAB CTR

0050088

Report Period Beginning:

1/1/12

Ending:

12/31/12

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		\$ 6,926,497	\$ 87,859		\$ 175,926	\$ 88,067	\$ 130,043	1
2	Installation of compressor	2012	750	19	39	10	(9)	19	2
3	Installation of compressor	2012	750	19	39	8	(11)	19	3
4	Prep, sand & paint walls, repair flooring, install new cove	2012	2,250	58	39	24	(34)	58	4
5	Take out old condensing unit	2012	1,250	32	39	13	(19)	32	5
6	Take out old flooring, install new flooring, paint walls	2012	1,350	35	39	14	(21)	35	6
7	Relace sinks, faucets & countertops	2012	900	23	39	10	(13)	23	7
8	Hoses, sprinklers, gas, pvc brushing, refrigerant cylinder	2012	549	14	39	7	(7)	14	8
9	Paint walls, install new flooring & cove base	2012	1,500	38	39	13	(25)	38	9
10	Remove old flooring, install new tiles, paint walls	2012	2,350	60	39	15	(45)	60	10
11	Paint walls, install new flooring & cove base	2012	2,700	69	39	12	(57)	69	11
12	Paint & supplies	2012	1,476	38	39	6	(32)	38	12
13	Paint & supplies	2012	2,072	53	39	9	(44)	53	13
14	Paint	2012	720	18	39	3	(15)	18	14
15	Paint walls, remove carpet, install new flooring	2012	850	22	39	4	(18)	22	15
16	Paint & supplies	2012	745	19	39	3	(16)	19	16
17	Paint walls, install new flooring & cove base	2012	1,500	38	39	6	(32)	38	17
18	paint wasll, treat mold, repair floors, install new floors	2012	1,800	46	39	8	(38)	46	18
19	Cut opening in ceiling for closet partitions	2012	2,100	54	39	9	(45)	54	19
20	Elevator pits	2012	5,300	136	39	91	(45)	136	20
21	Engineered drawings, hydraulic calculations, hydraulic placards	2012	10,800	277	39	162	(115)	277	21
22	Spinkler system	2012	92,810	2,380	39	397	(1,983)	2,380	22
23	Masonry repairs, roof maintenance, sheet metal repairs	2012	85,100	2,182	39	909	(1,273)	2,182	23
24		2012	2,244	58	39	29	(29)	58	24
25		2012	450	12	39	6	(6)	12	25
26	Install double egress hallway doors	2012	3,645	93	39	70	(23)	93	26
27	Install shunt trip breaker for elevator	2012	3,489	89	39	60	(29)	89	27
28	Kitchen hot water boiler	2012	16,745	429	39	179	(250)	429	28
29	Domestic water heat exchanger pump	2012	2,975	76	39	32	(44)	76	29
30	Domestic regulating valve rebuid and repair	2012	2,568	66	39	11	(55)	66	30
31	Heating boiler replacement	2012	16,895	433	39	108	(325)	433	31
32	Wall base	2012	1,032	26	39	15	(11)	26	32
33	Compressor installation	2012	5,896	151	39	76	(75)	151	33
34	TOTAL (lines 1 thru 33)		\$ 7,202,058	\$ 94,925		\$ 178,245	\$ 83,320	\$ 137,109	34

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

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		\$ 7,202,058	\$ 94,925		\$ 178,245	\$ 83,320	\$ 137,109	1
2	Compressor installation	2012	5,896	151	39	76	(75)	151	2
3	Power wash, paint and scape etire building	2012	15,950	409	39	102	(307)	409	3
4	Remove & install wall and delivery door	2012	1,300	33	39	8	(25)	33	4
5	Remove entire back patio, sidewalk	2012	16,000	410	39	103	(307)	410	5
6	Remove shrubbery by exit door	2012	775	20	39	5	(15)	20	6
7	Paint supplies	2012	1,237	32	39	5	(27)	32	7
8	Truck rental	2012	3,000	77	39	13	(64)	77	8
9	Repair, sand, prime, & paint walls, install new tiles	2012	860	22	39	17	(5)	22	9
10									10
11	Items deleted in FY10 and before capital rate reconciliation		30,735	788	39	738	(50)	2,383	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	TOTAL (lines 1 thru 33)		\$ 7,277,811	\$ 96,867		\$ 179,312	\$ 82,445	\$ 140,646	34

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

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	\$275,356	\$50,690	\$55,071	\$4,381	5	\$127,218	71
72	Current Year Purchases	763,998	206,664	94,769	(111,895)	5	206,665	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$1,039,354	\$257,354	\$149,840	\$(107,514)		\$333,883	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	2	
	Reference	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)	\$8,817,165	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$354,221	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$329,152	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(25,069)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$474,529	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: NILES NURSING REALTY
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:		304	3/31/10	\$ 685,573	25		3
4	Additions							4
5								5
6								6
7	TOTAL		304		\$ 685,573			7

10. Effective dates of current rental agreement:

Beginning

Ending

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

Fiscal Year Ending

Annual Rent

12. /2013\$
13. /2014\$
14. /2015\$

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: Purchased during 2012*

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.

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
☒ 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

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

In the box below record the amount of income your facility received training CNAs from other facilities.

		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)	\$			

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		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A-3	hrs	\$		\$ 228,300	\$		\$ 228,300	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs			208,343			208,343	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs			261,035			261,035	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-3	# of prescrpts				286,329		286,329	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): RADIOLOGY/LAB	39-3					9,075		9,075	13
14	TOTAL			\$		\$ 697,678	\$ 295,404		\$ 993,082	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.

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (262,030)	\$ 234,614	1
2	Cash-Patient Deposits	(1,225)	(1,225)	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	5,301,565	5,301,564	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	28,357	28,357	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,066,667	\$ 5,563,310	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		500,000	13
14	Buildings, at Historical Cost		6,000,000	14
15	Leasehold Improvements, at Historical Cost	1,277,811	1,277,811	15
16	Equipment, at Historical Cost	431,352	1,039,352	16
17	Accumulated Depreciation (book methods)	(359,760)	(474,530)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		18,185,064	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(504,224)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,349,403	\$ 26,023,473	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,416,070	\$ 31,586,783	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,574,690	\$ 1,748,540	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	483,366	483,366	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Working Capital	3,211,541	3,211,541	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,269,597	\$ 5,443,447	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		22,925,126	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)	\$	\$ 22,925,126	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,269,597	\$ 28,368,573	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,146,473	\$ 3,218,210	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,416,070	\$ 31,586,783	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 453,016	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 453,016	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,243,453	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised	(550,000)	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)	4	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 693,457	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)	\$ 1,146,473	24 *

* This must agree with page 17, line 47.

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.

	1		2
I. Revenue	Amount		
A. Inpatient Care			
1Gross Revenue -- All Levels of Care	\$ 15,794,486	1	
2Discounts and Allowances for all Levels	1,173,170	2	
3SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 16,967,656	3	
B. Ancillary Revenue			
4Day Care		4	
5Other Care for Outpatients		5	
6Therapy	157,471	6	
7Oxygen		7	
8SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 157,471	8	
C. Other Operating Revenue			
9Payments for Education		9	
10Other Government Grants		10	
11CNA Training Reimbursements		11	
12Gift and Coffee Shop		12	
13Barber and Beauty Care		13	
14Non-Patient Meals		14	
15Telephone, Television and Radio		15	
16Rental of Facility Space		16	
17Sale of Drugs		17	
18Sale of Supplies to Non-Patients		18	
19Laboratory		19	
20Radiology and X-Ray		20	
21Other Medical Services		21	
22Laundry		22	
23SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23	
D. Non-Operating Revenue			
24Contributions		24	
25Interest and Other Investment Income***	4,925	25	
26SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,925	26	
E. Other Revenue (specify):****			
27Settlement Income (Insurance, Legal, Etc.)		27	
28Vending	2,350	28	
28aMiscellaneous	17,383	28a	
29SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 19,733	29	
30TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 17,149,785	30	

	1		2
II. Expenses	Amount		
A. Operating Expenses			
31General Services	2,355,786	31	
32Health Care	6,858,051	32	
33General Administration	2,284,020	33	
B. Capital Expense			
34Ownership	2,651,325	34	
C. Ancillary Expense			
35Special Cost Centers	755,404	35	
36Provider Participation Fee	1,001,746	36	
D. Other Expenses (specify):			
37		37	
38		38	
39		39	
40TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 15,906,332	40	
41Income before Income Taxes (line 30 minus line 40)**	1,243,453	41	
42Income Taxes		42	
43NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,243,453	43	

III. Net Inpatient Revenue detailed by Payer Source			
44Medicaid - Net Inpatient Revenue	\$ 13,762,609	44	
45Private Pay - Net Inpatient Revenue	444,983	45	
46Medicare - Net Inpatient Revenue	2,673,038	46	
47Other-(specify)	87,026	47	
48Other-(specify)		48	
49TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 16,967,656	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.

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	1,848	1,984	\$ 106,831	\$ 53.85	1
2	Assistant Director of Nursing					2
3	Registered Nurses	55,342	60,966	1,962,391	32.19	3
4	Licensed Practical Nurses	31,215	34,185	861,806	25.21	4
5	CNAs & Orderlies	144,456	159,948	2,032,289	12.71	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	20,139	21,906	311,070	14.20	9
10	Activity Assistants					10
11	Social Service Workers	8,952	9,720	178,952	18.41	11
12	Dietician	36,317	39,844	520,152	13.05	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	7,727	8,514	93,785	11.02	17
18	Housekeepers	27,927	31,136	362,553	11.64	18
19	Laundry	9,055	10,428	115,943	11.12	19
20	Administrator	2,544	2,590	97,040	37.47	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,943	15,007	323,970	21.59	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	1,856	2,179	69,739	32.01	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	361,321	398,407	\$ 7,036,521 *	\$ 17.66	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	429	\$ 15,000	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	504	25,200	10-3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	581	29,061	15-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	387	13,540	12-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,901	\$ 82,801		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

STATE OF ILLINOIS

0050088

Report Period Beginning:

1/1/12

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Ending: 12/31/12

Facility Name & ID Number

NILES NRSG & REHAB CTR

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
JASON LEE	ADMIN		\$ 3,574	Workers' Compensation Insurance	\$	145,803	IDPH License Fee	\$ 1,990
MICHAEL PERL	ADMIN		93,466	Unemployment Compensation Insurance		125,152	Advertising: Employee Recruitment	
				FICA Taxes		600,894	Health Care Worker Background Check	
				Employee Health Insurance		260,323	(Indicate # of checks performed)	
				Employee Meals			Patient Background Checks	
				Illinois Municipal Retirement Fund (IMRF)*			CLERK CIRCUIT COURT	685
				UNIFORMS		9,874	IL COUNCIL	11,066
				PENSION		50,100	VILLAGE OF NILES	4,967
							COOK COUNTY	893
							OTHER FEES & LICENSES	3,254
							Less: Public Relations Expense	()
							Non-allowable advertising	()
							Yellow page advertising	()
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 97,040			TOTAL (agree to Sch. V, line 20, col. 8)	
B. Administrative - Other								
Description			Amount					
			\$					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)			\$ 1,192,146	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
BRADLEY & ASSOCAITES	ACCOUNTING	\$	9,965				Out-of-State Travel	\$
JOHNSON,GOLDBERG	ACCOUNTING		2,500					
IRA SILVERSTEIN	LEGAL		1,100					
MONOHAN LAW GROUP	LEGAL		1,777				In-State Travel	
CLARK HILL	LEGAL		1,000				AUTO ALLOWANCE	25,019
ELENORA HOLMES	LEGAL		710				MILEAGE	2,011
ELAINE SIT	LEGAL		562				EDUCATION	1,209
RIGHEIMER MARTIN	LEGAL		893				Seminar Expense	376
INFINITY HEALTHCARE	MANAGEMENT SVC		306,000				Travel	165
MTS CONSULTING	PROFESSIONAL FEES		282					
A&F REALTY	PROFESSIONAL FEES		20,000					
MICHAEL BLISKO	PROFESSIONAL FEES		39,000					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				\$ 383,789			Entertainment Expense ()	
							(agree to Sch. V, line 24, col. 8)	
							TOTAL \$ 28,780	

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

(1)	Are nursing employees (RN,LPN,NA) represented by a union?	<u>YES</u>	(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?	<u>YES</u>
(2)	Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount.	<u>NO</u> <u>N/A</u>	(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? <u>NO</u> 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.	
(3)	Did the nursing home make political contributions or payments to a political action organization? <u>NO</u> If YES, have these costs been properly adjusted out of the cost report? <u>N/A</u>		(15)	Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ <u>0</u> Has any meal income been offset against related costs? <u>N/A</u> Indicate the amount. \$ <u>N/A</u>	
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? <u>NO</u> If YES, what is the capacity? <u>N/A</u>		(16)	Travel and Transportation a. Are there costs included for out-of-state travel? <u>NO</u> If YES, attach a complete explanation. N/A b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>NO</u> If YES, please indicate the amount of income earned from such a program during this reporting period. \$ <u>N/A</u> c. What percent of all travel expense relates to transportation of nurses and patients? <u>0%</u> d. Have vehicle usage logs been maintained? <u>N/A</u> e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>N/A</u> f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? <u>YES</u> g. Does the facility transport residents to and from day training? <u>NO</u> Indicate the amount of income earned from providing such transportation during this reporting period. \$ <u>0</u>	
(5)	Have you properly capitalized all major repairs and equipment purchases? <u>YES</u> What was the average life used for new equipment added during this period? <u>5 YEARS</u>		(17)	Has an audit been performed by an independent certified public accounting firm? <u>NO</u> Firm Name: <u>N/A</u>	
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ <u>90,195</u> Line <u>10</u>		(18)	Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? <u>YES</u>	
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>YES</u> If NO, attach a complete explanation.		(19)	If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? <u>YES</u> Attach invoices and a summary of services for all architect and appraisal fees.	
(8)	Are you presently operating under a sale and leaseback arrangement? <u>NO</u> If YES, give effective date of lease. <u>N/A</u>				
(9)	Are you presently operating under a sublease agreement? YES <u>X</u> NO				
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. <u>N/A</u>				
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ <u>#####</u> 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? <u>NO</u> If YES, attach an explanation of the allocation.				