

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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: <u>0048215</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Belhaven Nursing & Rehab Ctr</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/16</u> to <u>12/31/16</u> 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.																							
Address: <u>11401 S Oakley Ave</u> <u>Chicago</u> <u>60643</u>																									
Number City Zip Code																									
County: <u>Cook</u>																									
Telephone Number: <u>708-449-1900</u> Fax # <u>773-583-3929</u>																									
HFS ID Number: _____		<table><tr><td rowspan="3">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Flora Reznik</u></td></tr><tr><td>(Title) <u>CFO</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Signed) _____</td></tr><tr><td>(Print Name and Title) <u>Daniel S. Gaafar</u> <u>Partner</u></td></tr><tr><td>(Firm Name & Address) <u>Bradley Associates</u> <u>201 S Capitol Ave, Suite 700, Indianapolis, IN 46225</u></td></tr><tr><td>(Telephone) <u>(317) 237-5500</u> Fax # <u>(317) 237-5503</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Flora Reznik</u>	(Title) <u>CFO</u>	Paid Preparer	(Signed) _____	(Print Name and Title) <u>Daniel S. Gaafar</u> <u>Partner</u>	(Firm Name & Address) <u>Bradley Associates</u> <u>201 S Capitol Ave, Suite 700, Indianapolis, IN 46225</u>	(Telephone) <u>(317) 237-5500</u> Fax # <u>(317) 237-5503</u>													
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	(Telephone) <u>(317) 237-5500</u> Fax # <u>(317) 237-5503</u>																								
Date of Initial License for Current Owners: <u>07/01/2006</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other _____</td><td>_____</td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☒ Limited Liability Co.	_____		☐ Trust	_____		☐ Other _____	_____
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	☒ Limited Liability Co.	_____																							
	☐ Trust	_____																							
	☐ Other _____	_____																							
In the event there are further questions about this report, please contact:		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																							
Name: <u>Daniel S. Gaafar</u> Telephone Number: <u>(317) 237-5500</u>																									
Email Address: _____																									

Facility Name & ID Number Belhaven Nursing & Rehab Ctr

0048215 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 <u>N/A</u>					
	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>221</u>	Skilled (SNF)	<u>221</u>	<u>80,886</u>	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	<u>221</u>	TOTALS	<u>221</u>	<u>80,886</u>	7

B. Census-For the entire report period.						
	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>57,878</u>	<u>1,984</u>	<u>6,247</u>	<u>66,109</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>57,878</u>	<u>1,984</u>	<u>6,247</u>	<u>66,109</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.73%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

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

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 7/1/2006

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 7/1/2006 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 221 and days of care provided 3,145

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/16 Fiscal Year: 12/31/16
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Belhaven Nursing & Rehab Ctr # 0048215 Report Period Beginning: 01/01/16 Ending: 12/31/16
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	354,032		77,334	431,366		431,366	(27,119)	404,247			1
2	Food Purchase		326,272		326,272		326,272	813	327,085			2
3	Housekeeping	332,438	83,407		415,845		415,845	515	416,360			3
4	Laundry	137,269	43,976		181,245		181,245		181,245			4
5	Heat and Other Utilities			339,653	339,653		339,653	695	340,348			5
6	Maintenance	73,134	85,695	105,673	264,502		264,502	1,247	265,749			6
7	Other (specify):*											7
8	TOTAL General Services	896,873	539,350	522,660	1,958,883		1,958,883	(23,849)	1,935,034			8
	B. Health Care and Programs											
9	Medical Director			16,000	16,000		16,000		16,000			9
10	Nursing and Medical Records	4,296,914	439,201	48,590	4,784,705		4,784,705	(26,603)	4,758,102			10
10a	Therapy			971,299	971,299		971,299		971,299			10a
11	Activities	146,257	35,812		182,069		182,069	3,269	185,338			11
12	Social Services	94,281		11,461	105,742		105,742		105,742			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* RX Consultant			19,422	19,422		19,422		19,422			15
16	TOTAL Health Care and Programs	4,537,452	475,013	1,066,772	6,079,237		6,079,237	(23,334)	6,055,903			16
	C. General Administration											
17	Administrative	93,158			93,158		93,158		93,158			17
18	Directors Fees											18
19	Professional Services			824,713	824,713		824,713	(128,626)	696,087			19
20	Dues, Fees, Subscriptions & Promotions			15,053	15,053		15,053	(237)	14,816			20
21	Clerical & General Office Expenses	277,395	69,641	100,415	447,451		447,451	143,214	590,665			21
22	Employee Benefits & Payroll Taxes			877,687	877,687		877,687	60,264	937,951			22
23	Inservice Training & Education											23
24	Travel and Seminar			13,872	13,872		13,872	1,594	15,466			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			994,708	994,708		994,708	202,975	1,197,683			26
27	Other (specify):*											27
28	TOTAL General Administration	370,553	69,641	2,826,448	3,266,642		3,266,642	279,184	3,545,826			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,804,878	1,084,004	4,415,880	11,304,762		11,304,762	232,001	11,536,763			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			94,550	94,550		94,550	411,434	505,984			30
31	Amortization of Pre-Op. & Org.							168,219	168,219			31
32	Interest			12,241	12,241		12,241	692,181	704,422			32
33	Real Estate Taxes			370,000	370,000		370,000	105,371	475,371			33
34	Rent-Facility & Grounds			974,170	974,170		974,170	(967,072)	7,098			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Replacement Tax			4,458	4,458		4,458		4,458			36
37	TOTAL Ownership			1,455,419	1,455,419		1,455,419	410,133	1,865,552			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			5,325	5,325		5,325		5,325			38
39	Ancillary Service Centers		209,861		209,861		209,861		209,861			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			498,386	498,386		498,386		498,386			42
43	Other (specify):* Bad Debt Exp			1,135,856	1,135,856		1,135,856	(1,135,856)				43
44	TOTAL Special Cost Centers		209,861	1,639,567	1,849,428		1,849,428	(1,135,856)	713,572			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,804,878	1,293,865	7,510,866	14,609,609		14,609,609	(493,722)	14,115,887			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	165,396	30		9
10	Interest and Other Investment Income	(48,943)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(51)	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	(2,555)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,135,856)	43		24
25	Fund Raising, Advertising and Promotional	(12,032)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(7,037)	various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,041,078)		\$	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)	547,356	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 547,356		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (493,722)		37

*These costs are only allowable if they are necessary to meet minimum
licensing standards. Attach a schedule detailing the items included
on these lines.

C. Are the following expenses included in Sections A to D of pages 3
and 4? If so, they should be reclassified into Section E. Please
reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Miscellaneous Income	\$ (6,439)	21	1
2	PAC Expenses	(598)	20	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
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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	(7,037)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Belhaven Nursing & Rehab Ctr # 0048215 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	(51)	(27,068)	0	0	0	0	0	0	0	0	0	(27,119)	1
2	Food Purchase	0	0	813	0	0	0	0	0	0	0	0	813	2
3	Housekeeping	0	0	515	0	0	0	0	0	0	0	0	515	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	695	0	0	0	0	0	0	0	0	0	695	5
6	Maintenance	0	1,247	0	0	0	0	0	0	0	0	0	1,247	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(51)	(25,126)	1,328	0	0	0	0	0	0	0	0	(23,849)	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	(26,603)	0	0	0	0	0	0	0	0	0	(26,603)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	3,269	0	0	0	0	0	0	0	0	3,269	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	(26,603)	3,269	0	0	0	0	0	0	0	0	(23,334)	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	(195,147)	66,521	0	0	0	0	0	0	0	0	(128,626)	19
20	Fees, Subscriptions & Promotions	(598)	361	0	0	0	0	0	0	0	0	0	(237)	20
21	Clerical & General Office Expenses	(21,026)	164,240	0	0	0	0	0	0	0	0	0	143,214	21
22	Employee Benefits & Payroll Taxes	0	60,264	0	0	0	0	0	0	0	0	0	60,264	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,594	0	0	0	0	0	0	0	0	0	1,594	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	425	202,550	0	0	0	0	0	0	0	0	202,975	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(21,624)	31,737	269,071	0	0	0	0	0	0	0	0	279,184	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(21,675)	(19,992)	273,668	0	0	0	0	0	0	0	0	232,001	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Belhaven Nursing & Rehab Ctr # 0048215 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	165,396	302	245,736	0	0	0	0	0	0	0	0	411,434	30
31	Amortization of Pre-Op. & Org.	0	0	168,219	0	0	0	0	0	0	0	0	168,219	31
32	Interest	(48,943)	0	741,124	0	0	0	0	0	0	0	0	692,181	32
33	Real Estate Taxes	0	0	105,371	0	0	0	0	0	0	0	0	105,371	33
34	Rent-Facility & Grounds	0	7,098	(974,170)	0	0	0	0	0	0	0	0	(967,072)	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	116,453	7,400	286,280	0	0	0	0	0	0	0	0	410,133	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(1,135,856)	0	0	0	0	0	0	0	0	0	0	(1,135,856)	43
44	TOTAL Special Cost Centers	(1,135,856)	0	0	0	0	0	0	0	0	0	0	(1,135,856)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,041,078)	(12,592)	559,948	0	0	0	0	0	0	0	0	(493,722)	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	35	Ambassador Nursing & Rehad Center	Chicago	Infinity Healthcare	Hillside	Consulting Co.
Moishe Gubin	35	City View Multicare Center	Cicero	Belhaven Realty, LLC		Realty Co.
A & F Realty	30	Continental Nursing & Rehab Center	Chicago			
		Forest View Rehab & Nursing Center	Itasca			
		Lakeview Nursing & Rehab Center	Chicago			
		Midway Neurological & Rehab Center	Bridgeview			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ 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)	
1	V	1	Dietary	\$ 41,221	Infinity Healthcare Management		\$ 14,153	\$ (27,068)	1
2	V	10	Nursing Wages	46,196	Infinity Healthcare Management		19,593	(26,603)	2
3	V	21	Office Wages		Infinity Healthcare Management				3
4	V	5	Utilities		Infinity Healthcare Management		695	695	4
5	V	6	Maintenance		Infinity Healthcare Management		1,247	1,247	5
6	V	19	Professional Services	347,775	Infinity Healthcare Management		152,628	(195,147)	6
7	V	21	Office Expense	104,133	Infinity Healthcare Management		268,373	164,240	7
8	V	22	Employee Benefit		Infinity Healthcare Management		60,264	60,264	8
9	V	24	Auto/Travel Expense	218	Infinity Healthcare Management		1,812	1,594	9
10	V	26	Insurance		Infinity Healthcare Management		425	425	10
11	V	30	Depreciation		Infinity Healthcare Management		302	302	11
12	V	34	Rent		Infinity Healthcare Management		7,098	7,098	12
13	V	20	Dues, Fees, Subs & Promotions		Infinity Healthcare Management		361	361	13
14	Total			\$ 539,543			\$ 526,951	\$ * (12,592)	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.

☒ X

 YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional Fees	\$	Belhaven Realty, LLC		\$ 66,521	\$ 66,521	15
16	V	21	Office Expense		Belhaven Realty, LLC				16
17	V	26	Insurance		Belhaven Realty, LLC		202,550	202,550	17
18	V	30	Depreciation		Belhaven Realty, LLC		245,736	245,736	18
19	V	31	Amortization		Belhaven Realty, LLC		168,219	168,219	19
20	V	32	Interest		Belhaven Realty, LLC		737,220	737,220	20
21	V	33	Property Taxes		Belhaven Realty, LLC		105,371	105,371	21
22	V	34	Rent	974,170	Belhaven Realty, LLC			(974,170)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V	2	Food Purchases		Infinity Healthcare Management		813	813	27
28	V	3	Housekeeping		Infinity Healthcare Management		515	515	28
29	V	11	Activities		Infinity Healthcare Management		3,269	3,269	29
30	V	32	Interest		Infinity Healthcare Management		3,904	3,904	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			\$ 974,170			\$ 1,534,118	\$ * 559,948	39

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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Momence Meadows Nursing & Rehab Ctr	Momence				1
2			Niles Nursing & Rehab Center	Niles				2
3			Oak Lawn Respiratory & Rehab Center	Oak Lawn				3
4			Parker Nursing & Rehab Center	Streator				4
5			Parkshore Estates Nursing & Rehab Ctr	Chicago				5
6			Southpoint Nursing & Rehab Center	Chicago				6
7			West Suburban Nursing & Rehab Center	Bloomington				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

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Belhaven Nursing & Rehab Ctr # 0048215 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	HUD Loan		X	Mortgage	\$86,255.00	5/19/16	\$ 19,356,000	\$ 19,308,382	6/1/46	3.4000	\$ 753,365	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$86,255.00		\$ 19,356,000	\$ 19,308,382			\$ 753,365	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 19,356,000	\$ 19,308,382			\$ 753,365	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 2015 report.			\$	179,646	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.)			\$	459,118	2
3. Under or (over) accrual (line 2 minus line 1).			\$	279,472	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	195,899	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.			\$	475,371	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011	377,566	8	
		2012	430,741	9	
		2013	413,096	10	
		2014	421,483	11	
		2015	459,118	12	
		FOR BHF USE ONLY			
		13	FROM R. E. TAX STATEMENT FOR 2015 \$		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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Belhaven Nursing & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0048215

CONTACT PERSON REGARDING THIS REPORT Daniel S. Gaafar

TELEPHONE (317) 237-5500 FAX #: (317) 237-5503

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 25-19-110-040-0000	Nursing Home	\$ 459,117.50	\$ 459,117.50
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 459,117.50	\$ 459,117.50

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

A. Square Feet:

78,370

B. General Construction Type:

Exterior

BRICK

Frame

STEEL

Number of Stories

3

C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(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).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☐

NO

If so, please complete the following:

1. Total Amount Incurred:

2,419,619

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

15

3. Current Period Amortization:

147,985

4. Dates Incurred:

PRIOR TO 04/11/2006

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.					
	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	FACILITY		4/11/2006	\$ 1,200,000	1
2					2
3	TOTALS			\$ 1,200,000	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	221		2006		\$ 5,996,000	\$ 153,744	39	\$ 153,744	\$ (0)	\$ 1,506,203	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Wanderguard Security Camera			7/25/2006	37,000	949	39	949		10,437	9
10	Improvements - Paint & Painting Supplies			10/1/2006	600	15	39	15		167	10
11	2nd Floor Remodeling - Cove Base for Rooms			11/1/2006	1,408	36	39	36		397	11
12	2nd Floor Remodeling - Wall Protection & Corner Guards			11/1/2006	2,372	61	39	61		670	12
13	2nd Floor Remodeling - Floor & Tile			11/1/2006	5,418	139	39	139		1,529	13
14	2nd Floor Remodeling - Paint & Painting Supplies			11/1/2006	14,919	383	39	383		4,210	14
15	2nd Floor Remodeling - Cove Base, Vertical Dividers, Wood Drift			11/1/2006	2,275	58	39	58		640	15
16											16
17	Fast Signs			1/9/2007	3,352	86	39	86		860	17
18	Draperies, Light Fixtures, Cascades			1/23/2007	19,454	499	39	499		4,989	18
19	Painting & Supplies			2/1/2007	1,500	38	39	38		382	19
20	Water Pump & Boiler Tank			2/26/2007	7,156	183	39	183		1,832	20
21	Paint & Supplies			3/1/2007	2,657	68	39	68		681	21
22	Paint & Supplies			4/1/2007	5,520	142	39	142		1,418	22
23	Wall Paper, Wall Protection			5/1/2007	7,306	187	39	187		1,872	23
24	Paint & Supplies			5/1/2007	4,746	122	39	122		1,218	24
25	Heating & Cooling Pump			5/7/2007	4,214	108	39	108		1,080	25
26	Paint & Supplies			6/1/2007	8,833	226	39	226		2,262	26
27	Air Handler			6/4/2007	6,160	158	39	158		1,580	27
28	Wall Protection & Corner Guards			6/27/2007	7,957	204	39	204		2,040	28
29	Paint & Supplies			7/1/2007	4,744	122	39	122		1,218	29
30	Paint & Supplies			8/1/2007	5,247	135	39	135		1,348	30
31	Electric Work			8/2/2007	5,438	139	39	139		1,392	31
32	A/C			8/8/2007	2,534	65	39	65		650	32
33	Paint & Supplies			9/1/2007	4,393	113	39	113		1,128	33
34	Paint & Supplies			10/1/2007	6,499	167	39	167		1,668	34
35	Lights, Wall Protection, Draperies			10/9/2007	27,168	697	39	697		6,968	35
36	Shower Valve			11/1/2007	3,650	94	39	94		938	36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Belhaven Nursing & Rehab Ctr

0048215

Report Period Beginning:

01/01/16

Ending:

12/31/16

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Paint & Supplies	11/1/2007	\$ 3,076	\$ 79	39	\$ 79	\$	\$ 789	37
38	Electric Work	11/9/2007	10,269	263	39	263		2,632	38
39	Wall Covering	11/28/2007	3,161	81	39	81		810	39
40	Hydraulic Valve	11/28/2007	4,207	108	39	108		1,079	40
41	Paint & Supplies	12/1/2007	2,065	53	39	53		530	41
42									42
43	Kickplates/Wallcoverings	1/11/2008	3,130	80	39	80		721	43
44	Kickplates/Wallcoverings	4/24/2008	4,179	107	39	107		964	44
45	Valve Replacement	5/13/2008	3,650	94	39	94		844	45
46	Cooling Tower	6/20/2008	4,093	105	39	105		945	46
47	Water Heater parts replacement	12/5/2008	1,516	39	39	39		351	47
48	Water Heater parts replacement	12/24/2008	969	25	39	25		224	48
49	Dining Room	1/15/2008	3,600	92	39	92		829	49
50	Paint/Remodel	2/5/2008	2,300	59	39	59		531	50
51	2nd Floor Paint/Remodel	4/4/2008	3,000	77	39	77		693	51
52	3rd Floor Paint/Remodel	5/16/2008	3,500	90	39	90		809	52
53	Paint/Remodel	5/22/2008	1,500	38	39	38		344	53
54	Remodel - Cabinets/Light Fixtures	9/12/2008	600	15	39	15		137	54
55	Remodel - Cabinets/Light Fixtures	9/12/2008	1,400	36	39	36		324	55
56	Remodel Supplies	10/14/2008	600	15	39	15		137	56
57	Remodel Supplies	1/15/2008	252	6	39	6		56	57
58	Remodel Supplies	2/5/2008	269	7	39	7		63	58
59	Remodel Supplies	4/14/2008	406	10	39	10		92	59
60	Remodel Supplies	4/21/2008	663	17	39	17		153	60
61	Remodel Supplies	4/23/2008	489	13	39	13		115	61
62	Remodel Supplies	5/16/2008	326	8	39	8		73	62
63	Remodel Supplies	5/22/2008	465	12	39	12		108	63
64	Remodel Supplies	9/11/2008	1,106	28	39	28		253	64
65	Remodel Supplies	9/2/2008	1,470	38	39	38		341	65
66	Remodel Supplies	9/12/2008	606	16	39	16		142	66
67	Elevator	4/10/2008	3,006	77	39	77		693	67
68	Elevator	7/21/2008	5,538	142	39	142		1,278	68
69	Elevator	12/26/2008	4,407	113	39	113		1,017	69
70	TOTAL (lines 4 thru 69)		\$ 6,274,338	\$ 160,881		\$ 160,881	\$ (0)	\$ 1,577,854	70

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

Facility Name & ID Number Belhaven Nursing & Rehab Ctr

0048215

Report Period Beginning:

01/01/16

Ending:

12/31/16

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 6,274,338	\$ 160,881		\$ 160,881	\$ (0)	\$ 1,577,854	1
2	Sprinkler Repairs	7/31/2008	537	14	39	14		125	2
3	Sprinkler Repairs	8/28/2008	653	17	39	17		152	3
4	Sprinkler Repairs	8/29/2008	1,510	39	39	39		350	4
5	Sprinkler Repairs	8/31/2008	1,980	51	39	51		458	5
6	Sprinkler Repairs	8/31/2008	1,156	30	39	30		269	6
7									7
8	Floor Tile	8/19/2009	23,845	611	39	611		4,889	8
9	Remove and Replace Floor Tile	7/8/2009	3,000	77	39	77		616	9
10	New Tile in Shower Room	9/28/2009	3,000	77	39	77		616	10
11	Install Sheetrock in Shower Room	11/18/2009	3,000	77	39	77		616	11
12	Install wood paneling, handrails, corner guards	12/30/2009	3,000	77	39	77		616	12
13	Install Doors, Frames, and Glass	10/20/2009	14,489	372	39	372		2,975	13
14	New Doors	4/16/2009	910	23	39	23		185	14
15	New Doors	6/3/2009	1,134	29	39	29		232	15
16	Repair Sinkhole, Repair Pavement, Reseal & Restripe Park.	4/3/2009	9,625	247	39	247		1,975	16
17	New Faucets and Drains	10/7/2009	2,235	57	39	57		457	17
18	New Faucets and Drains	12/28/2009	1,290	33	39	33		264	18
19	New Faucets and Drains	12/21/2009	1,725	44	39	44		353	19
20	New Faucets and Drains	12/21/2009	1,725	44	39	44		353	20
21	New Roofing	9/14/2009	68,755	1,763	39	1,763		14,104	21
22	New Roofing	10/16/2009	1,950	50	39	50		400	22
23	Install and Paint Over Water Lines	6/19/2009	785	20	39	20		160	23
24	Install and Paint Over Water Lines	5/21/2009	1,700	44	39	44		351	24
25	Removal of Old Doorings & Installation of Dura Glides	12/17/2009	12,315	316	39	316		2,527	25
26	Wall Coverings. Wall Tiles, Table Lamps, Ceiling Pendants	12/29/2009	25,004	641	39	641		5,128	26
27									27
28	Drywall & Construction Supplies	10/13/2010	1,302	33	39	33		232	28
29	Shower Remodeling, 2nd Floor	1/20/2010	3,000	77	39	77		539	29
30	Shower Remodeling, 2nd Floor - Fixing Cracked Tiles	2/3/2010	3,000	77	39	77		539	30
31	Replacement Ceiling Tiles	12/7/2010	2,750	71	39	71		496	31
32	Replacement Ceiling Tiles, Paint, Fixing Duct	12/16/2010	2,410	62	39	62		434	32
33	Cleaners, Paints, Door Hinges, Flooring	12/16/2010	1,216	31	39	31		217	33
34	TOTAL (lines 1 thru 33)		\$ 6,473,339	\$ 165,985		\$ 165,985	\$ (0)	\$ 1,618,482	34

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

Facility Name & ID Number Belhaven Nursing & Rehab Ctr

0048215

Report Period Beginning:

01/01/16

Ending:

12/31/16

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 6,473,339	\$ 165,985		\$ 165,985	\$ (0)	\$ 1,618,482	1
2	Hardware for Doors/Flooring	12/17/2010	1,746	45	39	45		315	2
3	Elevator	8/5/2010	153,000	3,923	39	3,923		31,228	3
4	Hinges, Paint, Glass, and Stainless Steel for Basement	6/24/2010	6,115	157	39	157		1,099	4
5	Metal Doors Setup	12/9/2010	6,175	158	39	158		1,107	5
6	Door Locks	12/14/2010	475	12	39	12		84	6
7									7
8	Concrete Work	9/27/2011	11,000	282	39	282		2,961	8
9	Concrete & Asphalt Work	9/27/2011	6,750	173	39	173		1,038	9
10	Asphalt Work	11/12/2011	1,575	40	39	40		240	10
11	Fire Alarm System Devices	5/27/2011	8,506	218	39	218		1,308	11
12	HUD Inspection Preparation	1/5/2011	5,325	137	39	137		822	12
13	Sprinkler Addition in Elevator Pit	9/27/2011	2,575	66	39	66		396	13
14	New Hydronic Heater	1/24/2011	5,470	140	39	140		840	14
15	Chiller Compressor Replacement	4/20/2011	10,300	264	39	264		1,584	15
16	Chiller & Cooling Tower Cleaning	5/4/2011	7,950	204	39	204		1,224	16
17	New Cooling Tower Fan Motor Pulley & Blower Belts	7/6/2011	4,318	111	39	111		666	17
18	Kitchen Air Handler	8/2/2011	1,245	32	39	32		192	18
19	Sewer Dig Up & Repair	6/9/2011	10,500	269	39	269		1,614	19
20	Replaced Broken Pipe& Filled Holes w/ Concrete	7/6/2011	5,200	133	39	133		798	20
21	Remodel Offices- Ceiling Tiles, Flooring, Lighting, Paint	11/30/2011	8,486	218	39	218		1,308	21
22	Remodel Nurses Stations- Lighting, Coffered Ceiling, Floor								22
23	Tile, New Work Stations, Sink, Paint	11/30/2011	107,949	2,768	39	2,768		16,608	23
24	Remodel Corridors- Lighting, Floor Tile, Ceiling Tile,								24
25	Wallcovering, Handrail, Corner Gauards, Paint Doors	11/30/2011	315,993	8,102	39	8,102		48,612	25
26	Remodel Dining Rooms- Lighting, Drywall, Floor Tile, Ceiling								26
27	Tile, Paint, Wallcoverings, Corner Gaurds, Roller Shades	11/30/2011	112,227	2,878	39	2,878		17,268	27
28	Remodel PT Room- Lighting, Tile, Paint, Cabinets, Countertops	11/30/2011	36,356	932	39	932		5,592	28
29	Elevators- New Flooring, Wall Panels, Wall Base, Ceiling	11/30/2011	18,834	483	39	483		2,898	29
30	Specialty Consultation re: Safety Code Surveys	6/20/2011	2,905	74	39	74		444	30
31	Develop Fires Saftey Evaluation System	8/25/2011	5,278	135	39	135		810	31
32	Ceiling Panel	1/3/2011	547	14	39	14		84	32
33	Smoke Damper	2/1/2010	3,900	100	39	100		600	33
34	TOTAL (lines 1 thru 33)		\$ 7,334,039	\$ 188,053		\$ 188,053	\$ (0)	\$ 1,760,222	34

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

Facility Name & ID Number Belhaven Nursing & Rehab Ctr

0048215

Report Period Beginning:

01/01/16

Ending:

12/31/16

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 7,334,039	\$ 188,053		\$ 188,053	\$ (0)	\$ 1,760,222	1
2	Insulated Unit	1/12/2011	760	19	39	19		115	2
3	Insulated Unit	1/25/2011	705	18	39	18		108	3
4	Building Light	11/11/2011	710	18	39	18		108	4
5	Metal Door	1/3/2011	6,560	168	39	168		1,008	5
6									6
7	Replaced/Reprogrammed Pull Station	1/9/2012	2,834	73	39	73		365	7
8	Sprinkler Work	1/18/2012	4,925	126	39	126		630	8
9	Installed Ductwork necessary for Oxygen Rooms	1/20/2012	4,645	119	39	119		595	9
10	Metal Doors	1/24/2012	1,215	31	39	31		155	10
11	Sales tax on Metal Doors	1/24/2012	85	2	39	2		10	11
12	Repair Roof	2/20/2012	3,600	92	39	92		460	12
13	Install 28 Smoke Detectors & Fire Alarm System	3/21/2012	9,102	233	39	233		1,165	13
14	Credit for Expense Claimed in PY	3/22/2012	(110,243)	(2,827)	39	(2,827)		(14,135)	14
15	Replace Cast Iron Pipe	4/4/2012	1,400	36	39	36		180	15
16	Mechanical Rooms Repairs	6/18/2012	1,100	28	39	28		140	16
17	Basement Bathroom Ventilation	8/21/2012	4,000	103	39	103		515	17
18	Repair Heating	8/22/2012	3,838	98	39	98		490	18
19	Lever lockset	8/29/2012	811	21	39	21		105	19
20	Lever Lockset	8/29/2012	2,572	66	39	66		330	20
21	Metal Doors	8/30/2012	4,450	114	39	114		570	21
22	Repair Heating	9/10/2012	1,970	51	39	51		255	22
23	New Flooring and walls throughout entire facility	11/1/2012	47,836	1,227	39	1,227		6,135	23
24	Misc Repairs to piping in kitchen	11/2/2012	3,100	79	39	79		395	24
25	Install Precision Lamps on first floor nurses station	11/2/2012	3,551	91	39	91		455	25
26	New Flooring and walls throughout entire facility	12/14/2012	50,586	1,297	39	1,297		6,485	26
27	New Flooring and walls throughout entire facility	12/14/2012	60,320	1,547	39	1,547		7,735	27
28									28
29	Items deleted in FY10 and before capital rate reconciliation		131,542	3,373	39	3,373		19,765	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,576,013	\$ 194,256		\$ 194,256	\$ (0)	\$ 1,794,361	34

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

Facility Name & ID Number Belhaven Nursing & Rehab Ctr

0048215

Report Period Beginning:

01/01/16

Ending:

12/31/16

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 7,576,013	\$ 194,256		\$ 194,256	\$ (0)	\$ 1,794,361	1
2	Freezer	2013	4,260	109	39	109		382	2
3	Five Star - Parking Lot	2013	8,750	224	39	224		784	3
4	Fire Alarm System	2013	13,058	335	39	335		1,172	4
5	Corridors, dining room shades	2013	51,560	1,322	39	1,322		4,627	5
6	Generator	2013	4,708	121	39	121		423	6
7	Floor fixtures 1st & 2nd floor	2013	3,975	102	39	102		357	7
8	Eidco Credit	2013	(50,586)	(1,297)	39	(1,297)		(4,540)	8
9	Sprinkler system	2013	6,299	162	39	162		567	9
10	Survey	2013	2,819	72	39	72		252	10
11	Housekeepers store room/bathroom in basement	2013	25,613	657	39	657		2,300	11
12	lighting in dining room	2013	53,560	1,373	39	1,373		4,806	12
13									13
14	Repair walk-in freezer in kitchen	2014	2,015	52	39	52		126	14
15	Install Imperial Water Booster	2014	3,020	77	39	77		160	15
16	New Asphalt on portion of parking lot next to wood fence	2014	850	22	39	22		66	16
17	Cover base/flooring in main hallway	2014	3,679	94	39	94		235	17
18	Remove existing carpet in lobby and replace	2014	3,001	77	39	77		186	18
19	Security Camera system	2014	5,722	147	39	147		331	19
20	Install cabinetry, mirror, lighting, and sinks in beauty shop	2014	4,400	113	39	113		273	20
21	Chiller	2014	6,995	179	39	179		462	21
22	Booster pump	2014	2,498	64	39	64		155	22
23	Boiler & heater	2014	2,057	53	39	53		123	23
24	Floors in beauty shop	2014	1,718	44	39	44		99	24
25	Supply and Install Cat 5E cables in patient rooms	2014	2,844	73	39	73		219	25
26	Take fire system offline, test system and valves, restore	2014	2,214	57	39	57		119	26
27	Washer	2014	9,900	254	39	254		550	27
28	Perform fire services evaluation system test	2014	4,855	124	39	124		352	28
29	Install new flooring and cove base in basement hallways	2014	3,273	84	39	84		245	29
30	Install signage outside of building	2014	6,670	171	39	171		518	30
31	Tile flooring in patient bathrooms	2014	3,476	89	39	89		260	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,769,213	\$ 199,210		\$ 199,210	\$ (0)	\$ 1,809,970	34

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

Facility Name & ID Number Belhaven Nursing & Rehab Ctr

0048215

Report Period Beginning:

01/01/16

Ending:

12/31/16

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 7,769,213	\$ 199,210		\$ 199,210	\$ (0)	\$ 1,809,970	1
2									2
3	Custom Cabinets & Walls in Rms 101,103, 117	2015	9,000	231	39	231		448	3
4	Hot Water Unit	2015	4,485	115	39	115		223	4
5	Fire Sprinkler System Upgrade	2015	4,042	104	39	104		201	5
6	Fire Sprinkler System - New Sprinkler Heads	2015	2,570	66	39	66		128	6
7	Freezer - Evaporator Coil	2015	3,650	94	39	94		182	7
8	Air Conditioner Repair	2015	2,587	66	39	66		128	8
9	Fire Alarm Bell, Smoke Detectors, Power Supply	2015	2,711	70	39	70		135	9
10	Cooler Tower Floatball and Screens	2015	4,233	109	39	109		211	10
11	Cooler Tower R-22 for Compressor	2015	3,080	79	39	79		153	11
12	Cooler Tower Sealing	2015	4,233	109	39	109		211	12
13	Vinyl Plank Flooring	2015	2,650	68	39	68		132	13
14	Cooler Tower Belts and Oiling	2015	2,573	66	39	66		128	14
15	Cooler Tower Algaecide Treatment	2015	3,191	82	39	82		159	15
16	Basement Water Lines	2015	6,800	174	39	174		338	16
17	Dishwasher Repiping of Sanitary Line	2015	3,010	77	39	77		150	17
18	Doors in Kitchen	2015	5,338	137	39	137		266	18
19	Low Pressure Water Feeder	2015	2,741	70	39	70		136	19
20									20
21	Repairs and Seal Coating	2016	17,205	441	39	441		441	21
22	Fire Alarm System / Repairs	2016	7,818	200	39	200		200	22
23	New Cooling Tower	2016	39,996	1,026	39	1,026		1,026	23
24	Repair Freon leak on unit	2016	7,876	202	39	202		202	24
25	Paint/Repair 1st floor doors	2016	8,160	209	39	209		209	25
26	Install new doors - 3rd floor	2016	11,338	291	39	291		291	26
27	Flooring repairs / tiling	2016	3,275	84	39	84		84	27
28	Doors	2016	2,710	69	39	69		69	28
29	Doors	2016	4,498	115	39	115		115	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,938,983	\$ 203,564		\$ 203,564	\$ (0)	\$ 1,815,936	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	\$636,000	\$92,295	\$127,200	\$34,905	5	\$331,714	71
72	Current Year Purchases	44,729	44,729	8,946	(35,783)	5-7	44,729	72
73	Fully Depreciated Assets	831,374		166,275	166,275	5-7	831,374	73
74								74
75	TOTALS	\$1,512,103	\$137,024	\$302,421	\$165,397		\$1,207,817	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)	\$10,651,086	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$340,588	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$505,984	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$165,396	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$3,023,753	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: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

☒ YES

☐ NO
- If NO, see instructions.

		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: *

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

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:
- | | Fiscal Year Ending | Annual Rent |
|-----|--------------------|-------------|
| 12. | | \$ |
| 13. | | \$ |
| 14. | | \$ |

* 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

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		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	\$	7,138	\$ 398,032	\$	7,138	\$ 398,032	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		1,457	90,517		1,457	90,517	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		5,552	358,999		5,552	358,999	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				192,899		192,899	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): XRAY	39-2					8,043		8,043	12
13	Other (specify): LAB	39-2					8,920		8,920	13
14	TOTAL			\$	14,147	\$ 847,548	\$ 209,862	14,147	\$ 1,057,410	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	\$ (183,026)	\$ 272,822	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	5,221,353	5,274,122	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	549,248	557,919	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	4,892,934	4,892,934	8
9	Other(specify):		229,559	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 10,480,509	\$ 11,227,356	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,200,000	13
14	Buildings, at Historical Cost		5,996,000	14
15	Leasehold Improvements, at Historical Cost	1,942,983	1,942,983	15
16	Equipment, at Historical Cost	876,103	1,512,103	16
17	Accumulated Depreciation (book methods)	(1,185,836)	(3,023,753)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	(171,734)	2,419,619	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(2,513,071)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	378,767	378,767	22
23	Other(specify):	5,435,737	6,232,080	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 7,276,020	\$ 14,144,728	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 17,756,529	\$ 25,372,084	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 11,150,374	\$ 11,528,674	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	60,045	60,045	28
29	Short-Term Notes Payable		433,158	29
30	Accrued Salaries Payable	194,574	194,574	30
31	Accrued Taxes Payable (excluding real estate taxes)	27,927	27,927	31
32	Accrued Real Estate Taxes(Sch.IX-B)	370,000	370,000	32
33	Accrued Interest Payable		54,574	33
34	Deferred Compensation	165	165	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)	\$ 11,803,085	\$ 12,669,117	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		18,875,224	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 18,875,224	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 11,803,085	\$ 31,544,341	46
47	TOTAL EQUITY(page 18, line 24)	\$ 5,953,444	\$ (6,172,257)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 17,756,529	\$ 25,372,084	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,795,951	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,795,951	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,157,492	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	1	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,157,493	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)	\$ 5,953,444	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Belhaven Nursing & Rehab Ctr

0048215

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 14,734,358	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 14,734,358	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	872,469	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 872,469	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	96,345	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,387	19
20	Radiology and X-Ray	4,925	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 105,657	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	48,177	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 48,177	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>Miscellaneous Revenue</u>	6,439	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 6,439	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 15,767,100	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,905,140	31
32	Health Care	5,807,343	32
33	General Administration	3,592,276	33
	B. Capital Expense		
34	Ownership	1,455,420	34
	C. Ancillary Expense		
35	Special Cost Centers	209,862	35
36	Provider Participation Fee	498,386	36
	D. Other Expenses (specify):		
37	<u>Bad Debt Expense</u>	1,135,856	37
38	<u>Medically Necessary Transportation</u>	5,325	38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,609,608	40
41	Income before Income Taxes (line 30 minus line 40)**	1,157,492	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,157,492	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 11,845,695	44
45	Private Pay - Net Inpatient Revenue	374,189	45
46	Medicare - Net Inpatient Revenue	1,261,419	46
47	Other-(specify) <u>Net Inpatient Revenue</u>	1,253,055	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 14,734,358	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	2,011	2,240	\$ 124,710	\$ 55.67	1
2	Assistant Director of Nursing	7,250	8,002	276,492	34.55	2
3	Registered Nurses	14,237	15,563	454,639	29.21	3
4	Licensed Practical Nurses	54,278	60,234	1,709,007	28.37	4
5	CNAs & Orderlies	130,192	142,427	1,584,082	11.12	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	10,414	11,952	146,257	12.24	9
10	Activity Assistants					10
11	Social Service Workers	4,712	5,278	94,281	17.86	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	24,931	28,209	354,032	12.55	15
16	Dishwashers					16
17	Maintenance Workers	3,650	4,105	73,134	17.82	17
18	Housekeepers	26,075	28,688	332,438	11.59	18
19	Laundry	9,144	10,466	137,269	13.12	19
20	Administrator	1,682	1,897	93,158	49.11	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	22,993	25,452	392,264	15.41	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	1,945	2,174	33,115	15.23	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	313,514	346,687	\$ 5,804,878 *	\$ 16.74	34

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	1,178	\$ 41,221	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	1,388	48,590	10-3	38
39	Pharmacist Consultant	388	19,422	15-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	2,475	123,750	10-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	264	9,251	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	5,693	\$ 242,234		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

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

** See instructions.

STATE OF ILLINOIS

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#

0048215

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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	
Solomon Mizrahi	Administrator		\$ 87,612	Workers' Compensation Insurance	\$ 136,255	IDPH License Fee	\$ 1,990	
Brad Fierce	Administrator		5,546	Unemployment Compensation Insurance	120,140	Advertising: Employee Recruitment		
				FICA Taxes	450,059	Health Care Worker Background Check		
				Employee Health Insurance	172,133	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		City of Chicago	4,250	
				Uniform Expense	5,103	Dept of Finance	360	
				Pension Expense	18,680	IHCA	7,705	
				Employee Expense	35,581	CLIA Lab Program	150	
TOTAL (agree to Schedule V, line 17, col. 1)						Infinity Healthcare	361	
(List each licensed administrator separately.)			\$ 93,158			Less: Public Relations Expense	()	
B. Administrative - Other						Non-allowable advertising	()	
Description			Amount			Yellow page advertising	()	
			\$					
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V,	\$ 937,951	TOTAL (agree to Sch. V,	\$ 14,816	
(Attach a copy of any management service agreement)				line 22, col.8)		line 20, col. 8)		
C. Professional Services				E. Schedule of Non-Cash Compensation Paid		G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Amount	
Bradley Associates	Accounting	\$	7,933			\$	Out-of-State Travel	
Johnson & Goldburg	Accounting		2,900					
Various	Accounting		5,798					
Lewis Brisbois, Bisgaard, & Smith	Legal		272,109				In-State Travel	
Swanson, Martin & Bell	Legal		49,732				Auto Allowance	
Clausen Miller	Legal		13,910				Mileage	
Segal McCambridge Singer & Mahon	Legal		12,823					
Quintairos, Prieto, Wood & Boyer	Legal		8,476				Seminar Expense	
Various	Legal		6,178				Education & Seminar	
MTS Consulting	Professional		13,906					
Pinnacle Quality	Professional		1,799					
Infinity Healthcare	Professional/Mgmt		429,149				Entertainment Expense	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	()	
(For legal fee disclosure, see page 39 of instructions)			\$ 824,713				(agree to Sch. V,	
							line 24, col. 8)	
							\$ 15,466	

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

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XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? YES
 If YES, give association name and amount. Illinois Council on Long Term Care

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

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A

(5) Have you properly capitalized all major repairs and equipment purchases? YES
 What was the average life used for new equipment added during this period? 5 Years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 93,712 Line 10-2

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 498,386
 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 benefit on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A

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

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

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. YES
 Attach invoices and a summary of services for all architect and appraisal fees