

Facility Name & ID Number NILES NURSING & REHABILITATION CENTER

0050088 Report Period Beginning: 1/1/09 Ending: 12/31/09

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	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>304</u>	Skilled (SNF)	<u>304</u>	<u>110,960</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>304</u>	TOTALS	<u>304</u>	<u>110,960</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	<u>72,946</u>	<u>845</u>	<u>5,958</u>	<u>79,749</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>72,946</u>	<u>845</u>	<u>5,958</u>	<u>79,749</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.87%

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 6/20/08

J. Was the facility purchased or leased after January 1, 1978?
YES Date 6/20/08 NO

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 5,148

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/09 Fiscal Year: 12/31/09

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

Facility Name & ID Number NILES NURSING & REHABILITATION CI # 0050088 Report Period Beginning: 1/1/09 Ending: 12/31/09

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	444,042	48,588	14,150	506,780		506,780	502	507,282		1
2	Food Purchase		415,784		415,784		415,784		415,784		2
3	Housekeeping	304,080	66,865		370,945		370,945		370,945		3
4	Laundry	128,410	35,267		163,677		163,677		163,677		4
5	Heat and Other Utilities			335,419	335,419		335,419	424	335,843		5
6	Maintenance	83,081	31,159	60,705	174,945		174,945	(3,122)	171,823		6
7	Other (specify):*										7
8	TOTAL General Services	959,613	597,663	410,274	1,967,550		1,967,550	(2,196)	1,965,354		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	4,105,630	356,280	29,236	4,491,146		4,491,146	11,080	4,502,226		10
10a	Therapy			579,195	579,195		579,195		579,195		10a
11	Activities	310,774	27,505		338,279		338,279		338,279		11
12	Social Services	108,346		5,970	114,316		114,316		114,316		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Pharmacy Consult.			5,236	5,236		5,236		5,236		15
16	TOTAL Health Care and Programs	4,524,750	383,785	631,637	5,540,172		5,540,172	11,080	5,551,252		16
	C. General Administration										
17	Administrative	77,598			77,598		77,598		77,598		17
18	Directors Fees										18
19	Professional Services			299,819	299,819		299,819	(241,589)	58,230		19
20	Dues, Fees, Subscriptions & Promotions			7,780	7,780		7,780		7,780		20
21	Clerical & General Office Expenses	244,531	112,354	50,620	407,505		407,505	44,139	451,644		21
22	Employee Benefits & Payroll Taxes			916,050	916,050		916,050	22,334	938,384		22
23	Inservice Training & Education										23
24	Travel and Seminar			34,390	34,390		34,390	5,989	40,379		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			240,975	240,975		240,975	(4,171)	236,804		26
27	Other (specify):*										27
28	TOTAL General Administration	322,129	112,354	1,549,634	1,984,117		1,984,117	(173,298)	1,810,819		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,806,492	1,093,802	2,591,545	9,491,839		9,491,839	(164,414)	9,327,425		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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			17,526	17,526		17,526	(1,695)	15,831			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			79,082	79,082		79,082		79,082			32
33	Real Estate Taxes							607,362	607,362			33
34	Rent-Facility & Grounds			3,600,000	3,600,000		3,600,000	(1,887,388)	1,712,612			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			3,696,608	3,696,608		3,696,608	(1,281,721)	2,414,887			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		216,111		216,111		216,111		216,111			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			166,440	166,440		166,440		166,440			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		216,111	166,440	382,551		382,551		382,551			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,806,492	1,309,913	6,454,593	13,570,998		13,570,998	(1,446,135)	12,124,863			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

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.)

		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	(1,695)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(43)	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	(29,705)	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				24
25	Fund Raising, Advertising and Promotional	(39,531)	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	(35,120)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (106,094)		\$	30

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)	(1,340,041)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,340,041)		36
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,446,135)		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

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' COMPILATION REPORT

NILES NURSING & REHABILITATION CENTER

ID# 0050088

Report Period Beginning: 1/1/09

Ending: 12/31/09

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	VENDING INCOME	\$ (3,122)	6	1
2	MISCELLANEOUS INCOME	(2,880)	21	2
3	INSURANCE REFUND	(29,098)	26	3
4	MEDICAL RECORDS INCOME	(20)	10	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	(35,120)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number NILES NURSING & REHABILITATION CENTER# 0050088

Report Period Beginning:

1/1/09

Ending:

12/31/09

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	(43)	545	0	0	0	0	0	0	0	0	0	502	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	424	0	0	0	0	0	0	0	0	0	424	5
6	Maintenance	(3,122)	0	0	0	0	0	0	0	0	0	0	(3,122)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(3,165)	969	0	0	0	0	0	0	0	0	0	(2,196)	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	(20)	11,100	0	0	0	0	0	0	0	0	0	11,080	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	(20)	11,100	0	0	0	0	0	0	0	0	0	11,080	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	(241,589)	0	0	0	0	0	0	0	0	0	(241,589)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(72,116)	116,255	0	0	0	0	0	0	0	0	0	44,139	21
22	Employee Benefits & Payroll Taxes	0	22,334	0	0	0	0	0	0	0	0	0	22,334	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	5,989	0	0	0	0	0	0	0	0	0	5,989	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(29,098)	517	24,410	0	0	0	0	0	0	0	0	(4,171)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(101,214)	(96,494)	24,410	0	(173,298)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(104,399)	(84,425)	24,410	0	(164,414)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number NILES NURSING & REHABILITATION CENTER# 0050088

Report Period Beginning:

1/1/09

Ending:

12/31/09

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(1,695)	0	0	0	0	0	0	0	0	0	0	(1,695)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	607,362	0	0	0	0	0	0	0	0	0	607,362	33
34	Rent-Facility & Grounds	0	(1,887,388)	0	0	0	0	0	0	0	0	0	(1,887,388)	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	(1,695)	(1,280,026)	0	0	0	0	0	0	0	0	0	(1,281,721)	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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(106,094)	(1,364,451)	24,410	0	(1,446,135)	45							

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHMENT #1						

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	10 NURSING	\$ 24,000	NEW YORK BOYS MANAGEMENT	46.25%	\$ 35,100	\$ 11,100	1
2	V	1 DIETARY	14,150	NEW YORK BOYS MANAGEMENT		14,695	545	2
3	V	5 UTILITIES		NEW YORK BOYS MANAGEMENT		424	424	3
4	V	21 OFFICE EXPENSE	11,935	NEW YORK BOYS MANAGEMENT		108,162	96,227	4
5	V	19 PROFESSIONAL SERVICES	246,600	NEW YORK BOYS MANAGEMENT		4,036	(242,564)	5
6	V	22 LIFE INSURANCE	1,482	NEW YORK BOYS MANAGEMENT		23,816	22,334	6
7	V	24 AUTO/TRAVEL EXPENSE		NEW YORK BOYS MANAGEMENT		5,989	5,989	7
8	V	34 FACILITY/GROUNDS		NEW YORK BOYS MANAGEMENT		813	813	8
9	V	26 INSURANCE		NEW YORK BOYS MANAGEMENT		517	517	9
10	V	21 OFFICE EXPENSE		NILES NURSING REALTY		20,028	20,028	10
11	V	19 PROFESSIONAL SERVICES		NILES NURSING REALTY		975	975	11
12	V	33 REAL ESTATE TAXES		NILES NURSING REALTY		607,362	607,362	12
13	V	34 RENT	3,600,000	NILES NURSING REALTY		1,711,799	(1,888,201)	13
14	Total		\$ 3,898,167			\$ 2,533,716	\$ * (1,364,451)	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	26 PROPERTY INSURANCE	\$	NILES NURSING REALTY		\$ 24,410	\$	24,410	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 24,410	\$ *	24,410	39

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

ATTACHMENT #1

OWNERS

NAME	OWNERSHIP %
MICHAEL BLISKO	36.000%
MOISHE GUBIN	40.000%
STEVEN BLISKO	4.000%
A&F GENERAL PARTNERSHIP	<u>20.000%</u>
	<u>100.000%</u>

OTHER RELATED BUSINESS ENTITIES

NAME	CITY	TYPE OF BUSINESS
NEW YORK BOYS MANAGEMENT	CROWN POINT, IN	MANAGEMENT CO.

NOTE: NEW YORK BOYS MANAGEMENT IS OWNED BY MOISHE GUBIN AND MICHAEL BLISKO.

Facility Name & ID Number NILES NURSING & REHABILITATION C # 0050088 Report Period Beginning: 1/1/09 Ending: 12/31/09

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number NILES NURSING & REHABILITATION CENTER # 0050088 Report Period Beginning: 1/1/09 Ending: 12/31/09

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number NILES NURSING & REHABILITATION CE # 0050088 Report Period Beginning: 1/1/09 Ending: 12/31/09

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										
										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										1									
2										2									
3										3									
4										4									
5										5									
Working Capital																			
6	BANK LEUMI USA	X	WORKING CAPITAL	NONE	7/18/08	2,500,000	1,805,000	4/15/10	4.5000	79,082	6								
7										7									
8										8									
9	TOTAL Facility Related					\$ 2,500,000	\$ 1,805,000			\$ 79,082	9								
B. Non-Facility Related*																			
10										10									
11										11									
12										12									
13										13									
14	TOTAL Non-Facility Related					\$	\$			\$	14								
15	TOTALS (line 9+line14)					\$ 2,500,000	\$ 1,805,000			\$ 79,082	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.) SEE ACCOUNTANTS' COMPILATION REPORT

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2008 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2008 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2008.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2008 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2009 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2008 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME NILES NURSING & REHABILITATION CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0050088

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 2008 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 2008.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>09-11-306-006-0000</u>	<u>NURSING FACILITY</u>	\$ <u>227,489.72</u>	\$ <u>227,489.72</u>
2. <u>09-11-306-005-0000</u>	<u>NURSING FACILITY</u>	\$ <u>227,568.89</u>	\$ <u>227,568.89</u>
3. <u>09-11-306-013-0000</u>	<u>NURSING FACILITY</u>	\$ <u>126,191.46</u>	\$ <u>126,191.46</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>581,250.07</u>	\$ <u>581,250.07</u>

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 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

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

Facility Name & ID Number NILES NURSING & REHABILITATION CENTER

0050088 Report Period Beginning:

1/1/09 Ending:

12/31/09

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: N/A B. General Construction Type: Exterior Frame Number of Stories

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: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number NILES NURSING & REHABILITATION CENTER

0050088

Report Period Beginning:

1/1/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Sprinkler Installation	2008		2,305	59	39	59	(0)	79	9
10		Fire Alarm Repairs	2008		1,701	44	39	44	(0)	47	10
11		Install Sign	2008		8,315	213	39	213	(0)	249	11
12		Prep Work for Sign Install	2008		2,800	72	39	72	(0)	84	12
13		Smoke Damper	2008		2,150	55	39	55	0	83	13
14		Boiler Pump Maintenance	2008		1,106	28	39	28	0	43	14
15		A/C - Water Chiller	2008		1,164	30	39	30	(0)	45	15
16		A/C - Unit Repair	2008		970	25	39	25	(0)	37	16
17		Fire Dampers	2008		5,543	142	39	142	0	201	17
18		Fixed Boiler for Hot Water	2008		1,348	35	39	35	0	49	18
19		A/C Compressor	2008		12,764	327	39	327	0	491	19
20		Freezer Repairs	2008		980	25	39	25	0	34	20
21		New Motor for Heater, Fix Pump, Boiler	2008		5,493	141	39	141	(0)	188	21
22		Hot Water Heater Repairs	2008		908	23	39	23	(0)	33	22
23		Freezer Repairs	2008		1,030	26	39	26	0	31	23
24		Dish Installation - Cable	2008		18,000	462	39	462	0	654	24
25		Cleared Short - Elevator	2008		754	19	39	19	0	29	25
26		Replaced Shorting Bar	2008		347	9	39	9	0	13	26
27		New Button for Elevator	2008		618	16	39	16	0	24	27
28		New Relay for Elevator	2008		300	8	39	8	(0)	12	28
29		New Door Contractor for Elevator	2008		685	18	39	18	(0)	26	29
30		New Contractors/Relays for Elevator	2008		1,157	30	39	30	0	42	30
31		Elevator Hydraulic Packing	2008		1,400	36	39	36	0	48	31
32		Elevator Hydraulic Oil, Seals, Rings	2008		5,190	133	39	133	0	155	32
33		Laundry Room Door Installation	2008		1,430	37	39	37	0	55	33
34		3rd Floor Exit Door	2008		1,323	34	39	34	(0)	51	34
35		Stop Strip for Door	2008		774	20	39	20	0	30	35
36		Door Replacement Parts	2008		940	24	39	24	(0)	36	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number NILES NURSING & REHABILITATION CENTER

0050088

Report Period Beginning:

1/1/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	Door Alarm Systems	2008	\$ 2,067	\$ 53	39	\$ 53	\$ (0)	\$ 57	37
38	Door Control Service Electric Work	2008	828	21	39	21	(0)	28	38
39	Signs	2008	271	7	39	7	0	9	39
40	Signs	2008	8,184	210	39	210	(0)	280	40
41	Painting 2nd Floor	2009	4,250	109	39	36	(73)	36	41
42	Painting 2nd Floor	2009	3,700	95	39	24	(71)	24	42
43	Paint Doors	2009	800	21	39	2	(19)	2	43
44	Remodeling/Painting Supplies	2009	455	12	39	8	(4)	8	44
45	Painting	2009	3,500	90	39	60	(30)	60	45
46	Painting	2009	3,500	90	39	60	(30)	60	46
47	Painting	2009	3,900	100	39	25	(75)	25	47
48	Painting	2009	3,500	90	39	15	(75)	15	48
49	Painting	2009	3,900	100	39	8	(92)	8	49
50	Floor Tiles	2009	5,904	151	39	126	(25)	126	50
51	Kitchen Doors	2009	1,500	38	39	38	(0)	38	51
52	Removate Hallways	2009	15,807	405	39	372	(34)	372	52
53	Renovate Lobby Floors	2009	4,060	104	39	87	(17)	87	53
54	Floor Tiles	2009	10,608	272	39	227	(45)	227	54
55	Fire Protection Sprinler Work	2009	45,518	1,167	39	1,070	(97)	1,070	55
56	Fire Protection Sprinler Work	2009	59,483	1,525	39	1,271	(254)	1,271	56
57	Install Exhaust Fan	2009	500	13	39	10	(3)	10	57
58	Relocate Drain Pipes	2009	2,525	65	39	49	(16)	49	58
59	Install Wiring & Pipes	2009	1,350	35	39	23	(12)	23	59
60	Install Wiring	2009	1,585	41	39	24	(17)	24	60
61	Install Windows	2009	1,300	33	39	25	(8)	25	61
62	Remove and Install New A/C	2009	39,000	1,000	39	583	(417)	583	62
63	A/C Installation	2009	2,392	61	39	31	(31)	31	63
64	A/C Installation	2009	2,200	56	39	19	(38)	19	64
65	Install Floor Tiles	2009	7,200	185	39	108	(77)	108	65
66	Furnishing of Signage	2009	2,218	57	39	33	(24)	33	66
67	Fire Sprinkler	2009	1,445	37	39	37	(0)	37	67
68	Painting	2009	3,500	90	39	37	(52)	37	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 328,445	\$ 8,422		\$ 6,787	\$ (1,635)	\$ 7,648	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 17,171	\$ 3,434	\$ 3,434	\$	5	\$ 4,820	71
72	Current Year Purchases	67,743	5,710	5,610	(100)	5	5,610	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 84,914	\$ 9,144	\$ 9,044	\$ (100)		\$ 10,430	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 413,359	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 17,526	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 15,831	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (1,695)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 18,077	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	\$ 1,712,612	2		3
4	Additions							4
5								5
6								6
7	TOTAL		304		\$ 1,712,612			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. 12/31/2010 \$ 1,712,612

13. 12/31/2011 \$ 1,712,612

14. 12/31/2012 \$ 428,153

* 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.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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

	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	\$		\$ 213,925	\$		\$ 213,925	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs			153,492			153,492	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs			211,778			211,778	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				208,581		208,581	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					7,530		7,530	13
14	TOTAL			\$		\$ 579,195	\$ 216,111		\$ 795,306	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **NILES NURSING & REHABILITATION CENTER**

0050088

Report Period Beginning: **1/1/09**

Ending: **12/31/09**

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/09** (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ (105,446)	\$ 61,287	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,831,870	4,406,870	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	394,428	1,610,962	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)	\$ 4,120,852	\$ 6,079,119	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	328,446	328,446	15
16	Equipment, at Historical Cost	84,914	84,914	16
17	Accumulated Depreciation (book methods)	(20,632)	(20,632)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			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)	\$ 392,728	\$ 392,728	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,513,580	\$ 6,471,847	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 2,036,147	\$ 2,036,147	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	671,433	671,433	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				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,707,580	\$ 2,707,580	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	1,805,000	1,805,000	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,805,000	\$ 1,805,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,512,580	\$ 4,512,580	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,000	\$ 1,959,267	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,513,580	\$ 6,471,847	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (355,736)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (355,736)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,445,728)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock	1,802,462	9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 356,734	17
	B. Transfers (Itemize):		
18	ROUNDING	2	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 2	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,000	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number NILES NURSING & REHABILITATION CENTE # 0050088 Report Period Beginning: 1/1/09

Ending: 12/31/09

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	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 11,469,090	1
2	Discounts and Allowances for all Levels	(396,802)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,072,288	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	826,559	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 826,559	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	163,564	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,691	19
20	Radiology and X-Ray	1,565	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 177,820	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING	3,122	28
28a	MISCELLANEOUS/INS. REFUND	45,481	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 48,603	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,125,270	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,967,550	31
32	Health Care	5,540,172	32
33	General Administration	1,984,117	33
B. Capital Expense			
34	Ownership	3,696,608	34
C. Ancillary Expense			
35	Special Cost Centers	216,111	35
36	Provider Participation Fee	166,440	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,570,998	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,445,728)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,445,728)	43

* 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. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **NILES NURSING & REHABILITATION CENTER**

0050088

Report Period Beginning:

1/1/09

Ending:

12/31/09

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	2,043	2,163	\$ 90,134	\$ 41.67	1
2	Assistant Director of Nursing					2
3	Registered Nurses	53,905	59,467	1,752,573	29.47	3
4	Licensed Practical Nurses	14,320	15,392	376,385	24.45	4
5	CNAs & Orderlies	129,704	144,205	1,823,225	12.64	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	21,405	23,568	310,774	13.19	9
10	Activity Assistants					10
11	Social Service Workers	5,346	5,970	108,346	18.15	11
12	Dietician	32,673	36,133	444,042	12.29	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	5,519	5,889	83,081	14.11	17
18	Housekeepers	25,485	28,274	304,080	10.75	18
19	Laundry	9,937	10,907	128,410	11.77	19
20	Administrator	2,069	2,127	77,598	36.48	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,080	10,894	244,531	22.45	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,395	4,485	63,313	14.12	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	316,881	349,474	\$ 5,806,492 *	\$ 16.61	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		\$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	585	29,236	10-3	38
39	Pharmacist Consultant	105	5,236	15-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	171	5,970	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	861	\$ 40,442		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

SEE ACCOUNTANTS' COMPILATION REPORT

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								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								
2																				
3																				
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	TOTALS		\$	\$	\$	\$	\$	\$	\$	\$	\$	\$								

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (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. \$ 19,077 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 166,440
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
 - c. What percent of all travel expense relates to transportation of nurses and patients? 0%
 - d. Have vehicle usage logs been maintained? N/A
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
 - 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. \$ 0
- (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) 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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT