



Facility Name & ID Number NILES NRSG & REHAB CENTER

# 0050088 Report Period Beginning: 1/1/13 Ending: 12/31/13

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>152</u>	Skilled (SNF)	<u>152</u>	<u>55,480</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>152</u>	Intermediate (ICF)	<u>152</u>	<u>55,480</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>304</u>	TOTALS	<u>304</u>	<u>110,960</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>46,062</u>	<u>1,154</u>	<u>3,019</u>	<u>50,234</u>	8
9	SNF/PED					9
10	ICF	<u>46,061</u>	<u>1,153</u>	<u>3,019</u>	<u>50,233</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>92,123</u>	<u>2,307</u>	<u>6,038</u>	<u>100,467</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.54%

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 5,953

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: 12/31/13 Fiscal Year: 12/31/13

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	546,509	63,701	13,621	623,831		623,831	(1,005)	622,826		1
2	Food Purchase		607,345		607,345		607,345	330	607,675		2
3	Housekeeping	445,380	76,992		522,372		522,372		522,372		3
4	Laundry	103,394	55,431		158,825		158,825		158,825		4
5	Heat and Other Utilities			362,104	362,104		362,104	1,962	364,066		5
6	Maintenance	100,554	48,403	91,576	240,533		240,533	2,940	243,473		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	1,195,837	851,872	467,301	2,515,010		2,515,010	4,227	2,519,237		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			22,000	22,000		22,000		22,000		9
10	Nursing and Medical Records	5,314,555	462,486	17,072	5,794,113		5,794,113	26,400	5,820,513		10
10a	Therapy			797,013	797,013		797,013		797,013		10a
11	Activities	343,032	55,865		398,897		398,897		398,897		11
12	Social Services	188,588		13,545	202,133		202,133		202,133		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <b>Pharmacy Consultant</b>			26,452	26,452		26,452		26,452		15
16	<b>TOTAL Health Care and Programs</b>	5,846,175	518,351	876,082	7,240,608		7,240,608	26,400	7,267,008		16
	<b>C. General Administration</b>										
17	Administrative	122,627			122,627		122,627		122,627		17
18	Directors Fees										18
19	Professional Services			397,260	397,260		397,260	(274,921)	122,339		19
20	Dues, Fees, Subscriptions & Promotions			43,957	43,957		43,957		43,957		20
21	Clerical & General Office Expenses	295,194	123,274	12,236	430,704		430,704	47,002	477,706		21
22	Employee Benefits & Payroll Taxes			1,281,067	1,281,067		1,281,067	32,439	1,313,506		22
23	Inservice Training & Education										23
24	Travel and Seminar			33,422	33,422		33,422	4,069	37,491		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			186,353	186,353		186,353	646	186,999		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	417,821	123,274	1,954,295	2,495,390		2,495,390	(190,765)	2,304,625		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	7,459,833	1,493,497	3,297,678	12,251,008		12,251,008	(160,138)	12,090,870		29

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

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

Facility Name & ID Number NILES NRSG & REHAB CENTER

#0050088

Report Period Beginning:

1/1/13

Ending:

12/31/13

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	<b>D. Ownership</b>											
30	Depreciation			399,108	399,108	399,108	17,361	416,469				30
31	Amortization of Pre-Op. & Org.			1,212,336	1,212,336	1,212,336		1,212,336				31
32	Interest			1,705,850	1,705,850	1,705,850	250	1,706,100				32
33	Real Estate Taxes			554,819	554,819	554,819		554,819				33
34	Rent-Facility & Grounds			2,940,000	2,940,000	2,940,000	(2,928,883)	11,117				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			6,812,113	6,812,113	6,812,113	(2,911,272)	3,900,841				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		262,725		262,725	262,725		262,725				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			739,915	739,915	739,915		739,915				42
43	Other (specify):* <b>Bad Debt</b>			427,595	427,595	427,595	(427,595)					43
44	<b>TOTAL Special Cost Centers</b>		262,725	1,167,510	1,430,235	1,430,235	(427,595)	1,002,640				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	7,459,833	1,756,222	11,277,301	20,493,356	20,493,356	(3,499,005)	16,994,351				45

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

Facility Name & ID Number NILES NRSRG & REHAB CENTER

# 0050088

Report Period Beginning: 1/1/13

Ending: 12/31/13

**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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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	17,361	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	(67)	1		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				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	(427,595)	43		24
25	Fund Raising, Advertising and Promotional	(39,166)	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	(3,003,698)	various		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (3,453,165)		\$	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	
		<b>Amount</b>	<b>Reference</b>	
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)	(45,840)	various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (45,840)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (3,499,005)		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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

<b>BHF USE ONLY</b>						
48		49		50		51
						52

NILES NRSG & REHAB CENTER

ID# 0050088

Report Period Beginning: 1/1/13

Ending: 12/31/13

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Vending Income	\$ (2,811)	6	1
2	Miscellaneous Revenue	(60,887)	21	2
3	rent	(2,940,000)	34	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(3,003,698)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number NILES NRSRG & REHAB CENTER# 0050088

Report Period Beginning:

1/1/13

Ending:

12/31/13

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(67)	(938)	0	0	0	0	0	0	0	0	0	(1,005)	1
2	Food Purchase	0	330	0	0	0	0	0	0	0	0	0	330	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	1,962	0	0	0	0	0	0	0	0	0	1,962	5
6	Maintenance	(2,811)	5,751	0	0	0	0	0	0	0	0	0	2,940	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(2,878)</b>	<b>7,105</b>	<b>0</b>	<b>4,227</b>	<b>8</b>								
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	26,400	0	0	0	0	0	0	0	0	0	26,400	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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>26,400</b>	<b>0</b>	<b>26,400</b>	<b>16</b>								
	<b>C. General Administration</b>													
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	(274,921)	0	0	0	0	0	0	0	0	0	(274,921)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(100,053)	147,055	0	0	0	0	0	0	0	0	0	47,002	21
22	Employee Benefits & Payroll Taxes	0	32,439	0	0	0	0	0	0	0	0	0	32,439	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	4,069	0	0	0	0	0	0	0	0	0	4,069	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	646	0	0	0	0	0	0	0	0	0	646	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(100,053)</b>	<b>(90,712)</b>	<b>0</b>	<b>(190,765)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(102,931)</b>	<b>(57,207)</b>	<b>0</b>	<b>(160,138)</b>	<b>29</b>								

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number NILES NRSRG & REHAB CENTER# 0050088

Report Period Beginning:

1/1/13

Ending:

12/31/13

## 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)	
	<b>D. Ownership</b>													
30	Depreciation	17,361	0	0	0	0	0	0	0	0	0	0	17,361	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	250	0	0	0	0	0	0	0	0	0	250	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(2,940,000)	11,117	0	0	0	0	0	0	0	0	0	(2,928,883)	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	<b>TOTAL Ownership</b>	<b>(2,922,639)</b>	<b>11,367</b>	<b>0</b>	<b>(2,911,272)</b>	<b>37</b>								
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	(427,595)	0	0	0	0	0	0	0	0	0	0	(427,595)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(427,595)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(427,595)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(3,453,165)</b>	<b>(45,840)</b>	<b>0</b>	<b>(3,499,005)</b>	<b>45</b>								

**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Michael Blisko	40			Infinity Healthcare	Hillside	Management Co
Moishe Gubin	40					
A&F General Partnership	20					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	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	\$ 13,621	INFINITY HEALTHCARE MANAGEMENT		\$ 12,683	\$ (938)	1
2	V	2	(330)	INFINITY HEALTHCARE MANAGEMENT			330	2
3	V	5		INFINITY HEALTHCARE MANAGEMENT		1,962	1,962	3
4	V	6		INFINITY HEALTHCARE MANAGEMENT		5,751	5,751	4
5	V	10	17,006	INFINITY HEALTHCARE MANAGEMENT		43,406	26,400	5
6	V	19	276,310	INFINITY HEALTHCARE MANAGEMENT		1,389	(274,921)	6
7	V	21	12,901	INFINITY HEALTHCARE MANAGEMENT		159,956	147,055	7
8	V	32		INFINITY HEALTHCARE MANAGEMENT		250	250	8
9	V	24	68	INFINITY HEALTHCARE MANAGEMENT		4,137	4,069	9
10	V	26		INFINITY HEALTHCARE MANAGEMENT		646	646	10
11	V	34		INFINITY HEALTHCARE MANAGEMENT		11,117	11,117	11
12	V	22	1,576	INFINITY HEALTHCARE MANAGEMENT		34,015	32,439	12
13	V							13
14	Total		\$ 321,152			\$ 275,312	\$ * (45,840)	14

\* 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								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								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number NILES NRSG & REHAB CENTER # 0050088 Report Period Beginning: 1/1/13 Ending: 12/31/13

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 NILES NRSG & REHAB CENTER

# 0050088

Report Period Beginning:

1/1/13

Ending: 12/31/13

**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

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number NILES NRSRG & REHAB CENTER

# 0050088

Report Period Beginning:

1/1/13

Ending:

12/31/13

**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	Name of Lender	2		3	4	5	6		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			
<b>A. Directly Facility Related</b>																	
<b>Long-Term</b>																	
1	Capital One		x	Mortgage	\$101,325.00	8/21/12	\$ 16,500,000	\$ 16,107,168	08/21/17	5.5000	\$ 908,549						
2	Strawberry Patch		x	Mortgage	int only		6,500,000	6,500,000	various	10.0000	520,000						
3																	
4																	
5																	
<b>Working Capital</b>																	
6	Capital One		x	working capital	none	8/31/12	1,195,065	1,195,065	8/31/15	various	51,798						
7	Infinity Funding	x		working capital	none	various	2,974,241	2,974,241	various	various	225,503						
8																	
9	<b>TOTAL Facility Related</b>				<b>\$101,325.00</b>		<b>\$ 27,169,306</b>	<b>\$ 26,776,474</b>			<b>\$ 1,705,850</b>						
<b>B. Non-Facility Related*</b>																	
10																	
11																	
12																	
13																	
14	<b>TOTAL Non-Facility Related</b>						<b>\$</b>	<b>\$</b>			<b>\$</b>						
15	<b>TOTALS (line 9+line14)</b>						<b>\$ 27,169,306</b>	<b>\$ 26,776,474</b>			<b>\$ 1,705,850</b>						

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**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2012 report.		\$	<b>21,263</b>		<b>1</b>
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.)		\$	<b>610,192</b>		<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>588,929</b>		<b>3</b>
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>(34,110)</b>		<b>4</b>
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$			<b>5</b>
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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$			<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>554,819</b>		<b>7</b>
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2008	<b>581,250</b>	<b>8</b>	<b>FOR BHF USE ONLY</b>	
	2009	<b>668,938</b>	<b>9</b>	<b>13</b>	FROM R. E. TAX STATEMENT FOR 2012 \$ <b>13</b>
	2010	<b>613,791</b>	<b>10</b>	<b>14</b>	PLUS APPEAL COST FROM LINE 5 \$ <b>14</b>
	2011	<b>621,420</b>	<b>11</b>	<b>15</b>	LESS REFUND FROM LINE 6 \$ <b>15</b>
	2012	<b>610,192</b>	<b>12</b>	<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION \$ <b>16</b>

**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.**



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                 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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: N/A B. General Construction Type: Exterior CONCRETE Frame STEEL Number of Stories 6

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

---

---

---

---

---

---

---

---

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
 If so, please complete the following:

1. Total Amount Incurred: 18,185,064 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
 3. Current Period Amortization: 1,212,336 4. Dates Incurred: PRIOR TO 8/31/12

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	nursing home		2012	\$ 500,000	1
2					2
3	TOTALS			\$ 500,000	3

Facility Name &amp; ID Number NILES NRSNG &amp; REHAB CENTER

# 0050088

Report Period Beginning:

1/1/13

Ending:

12/31/13

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	304		2012		\$ 6,000,000	\$ 161,083	39	\$ 153,846	\$ (7,237)	\$ 225,186	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Signs		2008		271	7	39	7		39	9
10	Signs		2008		8,184	210	39	210		1,172	10
11	Sprinkler Installation		2008		2,305	59	39	59		330	11
12	Fire Alarm Repairs		2008		1,701	44	39	44		244	12
13	Install Sign		2008		8,315	213	39	213		1,191	13
14	Prep Work for Sign Install		2008		2,800	72	39	72		401	14
15	Smoke Damper		2008		2,150	55	39	55		308	15
16	Boiler Pump Maintenance		2008		1,106	28	39	28		158	16
17	A/C - Water Chiller		2008		1,164	30	39	30		167	17
18	A/C - Unit Repair		2008		970	25	39	25		139	18
19	Fire Dampers		2008		5,543	142	39	142		794	19
20	Fixed Boiler for Hot Water		2008		1,348	35	39	35		193	20
21	A/C Compressor		2008		12,764	327	39	327		1,827	21
22	Freezer Repairs		2008		980	25	39	25		140	22
23	New Motor for Heater, Fix Pump, Boiler		2008		5,493	141	39	141		787	23
24	Hot Water Heater Repairs		2008		908	23	39	23		130	24
25	Freezer Repairs		2008		1,030	26	39	26		147	25
26	Dish Installation - Cable		2008		9,000	231	39	231		1,288	26
27	Cleared Short - Elevator		2008		754	19	39	19		108	27
28	Replaced Shorting Bar		2008		347	9	39	9		50	28
29	New Button for Elevator		2008		618	16	39	16		88	29
30	New Relay for Elevator		2008		300	8	39	8		43	30
31	New Door Contractor for Elevator		2008		685	18	39	18		98	31
32	New Contractors/Relays for Elevator		2008		1,157	30	39	30		166	32
33	Elevator Hydraulic Packing		2008		1,400	36	39	36		200	33
34	Elevator Hydraulic Oil, Seals, Rings		2008		5,190	133	39	133		743	34
35	Laundry Room Door Installation		2008		1,430	37	39	37		205	35
36	3rd Floor Exit Door		2008		1,323	34	39	34		189	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 &amp; ID Number NILES NRSNG &amp; REHAB CENTER

# 0050088

Report Period Beginning:

1/1/13

Ending:

12/31/13

## 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	Stop Strip for Door	2008	\$ 774	\$ 20	39	\$ 20	\$	\$ 111	37
38	Door Replacement Parts	2008	940	24	39	24		135	38
39	Door Alarm Systems	2008	2,067	53	39	53		296	39
40	Door Control Service Electric Work	2008	828	21	39	21		119	40
41	Painting 2nd Floor	2009	4,250	109	39	109		545	41
42	Painting 2nd Floor	2009	3,700	95	39	95		474	42
43	Paint Doors	2009	800	21	39	21		103	43
44	Remodeling/Painting Supplies	2009	455	12	39	12		58	44
45	Painting	2009	3,500	90	39	90		449	45
46	Painting	2009	3,500	90	39	90		449	46
47	Painting	2009	3,900	100	39	100		500	47
48	Painting	2009	3,500	90	39	90		449	48
49	Painting	2009	3,900	100	39	100		500	49
50	Floor Tiles	2009	5,904	151	39	151		757	50
51	Kitchen Doors	2009	1,500	38	39	38		192	51
52	Removate Hallways	2009	6,000	154	39	154		769	52
53	Renovate Lobby Floors	2009	4,060	104	39	104		520	53
54									54
55	Fire Protection Sprinler Work	2009	45,518	1,167	39	1,167		5,836	55
56	Fire Protection Sprinler Work	2009	59,483	1,524	39	1,525	1	7,626	56
57	Install Exhaust Fan	2009	500	13	39	13		64	57
58	Relocate Drain Pipes	2009	2,525	65	39	65		324	58
59	Install Wiring & Pipes	2009	1,350	35	39	35		173	59
60	Install Wiring	2009	1,585	41	39	41		203	60
61	Install Windows	2009	1,300	33	39	33		167	61
62	Remove and Install New A/C	2009	38,840	996	39	996		4,979	62
63	A/C Installation	2009	2,392	61	39	61		307	63
64	A/C Installation	2009	2,200	56	39	56		282	64
65	Install Floor Tiles	2009	7,200	185	39	185		923	65
66	Furnishing of Signage	2009	2,218	57	39	57		284	66
67	Fire Sprinkler	2009	1,445	37	39	37		185	67
68	Painting	2009	3,500	90	39	90		449	68
69	Install Extra Insulation	2010	1,105	28	39	28		113	69
70	TOTAL (lines 4 thru 69)		\$ 6,299,975	\$ 168,776		\$ 161,540	\$ (7,236)	\$ 264,872	70

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

Facility Name &amp; ID Number NILES NRSNG &amp; REHAB CENTER

# 0050088

Report Period Beginning:

1/1/13

Ending:

12/31/13

**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	<b>Totals from Page 12A, Carried Forward</b>		\$ 6,299,975	\$ 168,776		\$ 161,540	\$ (7,236)	\$ 264,872	1
2	Remove and Replaced Existing Carpet Tile	2010	573	15	39	15		59	2
3	Grain Quarry Tile Materials and Freight	2010	797	20	39	20		82	3
4	Paint Nursing Station and Baseboards	2010	830	21	39	21		85	4
5	Freeyer Floor and Dishwasher Sink	2010	530	14	39	14		54	5
6	Patched/Painted Walls, Handrails, Double Doors	2010	3,200	82	39	82		328	6
7	Granite and Paint Supplies	2010	710	18	39	18		73	7
8	Painting on 3rd and 4th Floor	2010	1,635	42	39	42		168	8
9	Marble Tile and Labor	2010	1,000	26	39	26		103	9
10	Install Toilet Bowls	2010	327	8	39	8		34	10
11	Install Toilet Bowls	2010	327	8	39	8		34	11
12	Removed and Installed New Carpet	2010	1,500	38	39	38		154	12
13	Install New Kitchen Tiles	2010	1,174	30	39	30		120	13
14	Tuckpointing	2010	2,215	57	39	57		227	14
15	Paint	2010	1,887	48	39	48		194	15
16	Paint and Semi-Gloss	2010	661	17	39	17		68	16
17	Paint	2010	661	17	39	17		68	17
18	Paint and Primer	2010	818	21	39	21		84	18
19	Paint	2010	758	19	39	19		78	19
20	Painting & Wallpapering	2010	1,556	40	39	40		160	20
21	Replaced Compressor and Labor	2010	9,500	244	39	244		973	21
22	Install New High Pressure Sodium Light Fixture	2010	880	23	39	23		90	22
23	New Venolation Air Handler	2010	1,050	27	39	27		108	23
24	Repair & Replace Hot Gas Line	2010	6,050	155	39	155		620	24
25	Repair & Repave Sidewalks & Parking Lot	2010	30,390	780	39	779	(1)	3,116	25
26	Install New Showers and & Water system	2011	154,527	3,963	39	3,962	(1)	11,887	26
27	Replace Lighting	2011	1,185	30	39	30		91	27
28	Repair Main Electrical Distribution Box, Install New Outlets & Sw	2011	8,950	229	39	229		688	28
29	Fix Small Steamer and Mount Wire & Install Circulating A/C Pun	2011	4,230	108	39	108		325	29
30	Replace Compressor on Air Conditioning Chiller	2011	11,624	298	39	298		894	30
31	Replace Ignifion Control On Boilers	2011	1,103	28	39	28		85	31
32	Repair & Seal Power Line Shaft & Remove Rust and Reapir Wall	2011	5,750	147	39	147		442	32
33	Modernize Two 5 Stop Passenger Elevators	2011	143,386	3,678	39	3,677	(1)	11,030	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,699,759	\$ 179,027		\$ 171,788	\$ (7,239)	\$ 297,394	34

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

Facility Name &amp; ID Number NILES NRSRG &amp; REHAB CENTER

# 0050088

Report Period Beginning:

1/1/13

Ending:

12/31/13

**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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 6,699,759	\$ 179,027		\$ 171,788	\$ (7,239)	\$ 297,394	1
2	Modernize Two 5 Stop Passenger Elevators	2011	104,672	2,684	39	2,684		8,053	2
3	Paint & Materials for First Floor Renevations	2011	654	17	39	17		50	3
4	Install New Tile, Sand & Paint Walls, Replace Plumbing	2011	3,850	99	39	99		296	4
5	Install New Floor, Move Electrical Outlers, Install Chair Rail	2011	6,280	161	39	161		483	5
6	Install Sprinkler Heads in Laundry Room	2011	925	24	39	24		71	6
7	Recharge Antifreeze System/Change OS&Y Valve	2011	2,998	77	39	77		231	7
8	Retrofit Lights	2011	40,064	1,027	39	1,027		3,083	8
9	Recharge Antifreeze System, Refill Freon, Repair A/C	2011	34,518	885	39	885		2,655	9
10	Replace Doors & Locks	2011	517	13	39	13		40	10
11									11
12	Replace hot water risers, shower drains, p-traps	2012	6,000	154	39	154		308	12
13	Fire alarn system install	2012	3,000	77	39	77		154	13
14	Fire alarn system install	2012	2,800	72	39	72		144	14
15	Install sink drain 7 p-trap, patch floor	2012	2,200	56	39	56		113	15
16	Vinyl plank flooring	2012	3,086	79	39	79		158	16
17	Ceiling panels, padlocks, screws, motor & condensor wheels	2012	3,051	78	39	78		156	17
18	TV remotes, batteries, powerstrips, cable	2012	1,118	29	39	29		57	18
19	Vinyl cve base, outlet grounded powerstrip	2012	528	14	39	14		27	19
20	Vinyl cve base case	2012	349	9	39	9		18	20
21	Install sink drains w grades & p-trap, patch floor	2012	2,200	56	39	56		113	21
22		2012	1,098	28	39	28		56	22
23	Repair, sand, prime, & paint walls, install new tiles	2012	860	22	39	22		44	23
24	Repair, sand, prime, & paint walls, install new tiles	2012	860	22	39	22		44	24
25	Remove wall paper & molds, install tiles, repair & paint walls	2012	970	25	39	25		50	25
26	Remove wall paper & molds, repair & paint walls	2012	540	14	39	14		28	26
27	Paint, prime, sand	2012	540	14	39	14		28	27
28	Install wooden fence	2012	400	10	39	10		21	28
29	Paint wall	2012	270	7	39	7		14	29
30	Install exhaust fans & grills	2012	450	12	39	12		23	30
31	Remove molds, paint walls, install exhaust fans	2012	500	13	39	13		26	31
32	Compressor installation	2012	600	15	39	15		31	32
33	Replace core, dryer, refrigerant	2012	841	22	39	22		43	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,926,497	\$ 184,842		\$ 177,603	\$ (7,239)	\$ 314,012	34

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

Facility Name &amp; ID Number NILES NRSG &amp; REHAB CENTER

**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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12C, Carried Forward</b>		\$ 6,926,497	\$ 184,842		\$ 177,603	\$ (7,239)	\$ 314,012	1
2	Installation of compressor	2012	750	19	39	19		38	2
3	Installation of compressor	2012	750	19	39	19		38	3
4	Prep, sand & paint walls, repair flooring, install new cove	2012	2,250	58	39	58		115	4
5	Take out old condensing unit	2012	1,250	32	39	32		64	5
6	Take out old flooring, install new flooring, paint walls	2012	1,350	35	39	35		69	6
7	Relace sinks, faucets & countertops	2012	900	23	39	23		46	7
8	Hoses, sprinklers, gas, pvc brushing, refrigerant cylinder	2012	549	14	39	14		28	8
9	Paint walls, install new flooring & cove base	2012	1,500	38	39	38		77	9
10	Remove old flooring, install new tiles, paint walls	2012	2,350	60	39	60		121	10
11	Paint walls, install new flooring & cove base	2012	2,700	69	39	69		138	11
12	Paint & supplies	2012	1,476	38	39	38		76	12
13	Paint & supplies	2012	2,072	53	39	53		106	13
14	Paint	2012	720	18	39	18		37	14
15	Paint walls, remove carpet, install new flooring	2012	850	22	39	22		44	15
16	Paint & supplies	2012	745	19	39	19		38	16
17	Paint walls, install new flooring & cove base	2012	1,500	38	39	38		77	17
18	paint wasll, treat mold, repair floors, install new floors	2012	1,800	46	39	46		92	18
19	Cut opening in ceiling for closet partitions	2012	2,100	54	39	54		108	19
20	Elevator pits	2012	5,300	136	39	136		272	20
21	Engineered drawings, hydraulic calculations, hvdraulic placards	2012	10,800	277	39	277		554	21
22	Spinkler system	2012	92,810	2,381	39	2,380	(1)	4,759	22
23	Masonry repairs, roof maintenance, sheet metal repairs	2012	85,100	2,183	39	2,182	(1)	4,364	23
24		2012	2,244	58	39	58		115	24
25		2012	450	12	39	12		23	25
26	Install double egress hallway doors	2012	3,645	93	39	93		187	26
27	Install shunt trip breaker for elevator	2012	3,489	89	39	89		179	27
28	Kitchen hot water boiler	2012	16,745	429	39	429		859	28
29	Domestic water heat exchanger pump	2012	2,975	76	39	76		153	29
30	Domestic regulating valve rebuid and repair	2012	2,568	66	39	66		132	30
31	Heating boiler replacement	2012	16,895	433	39	433		866	31
32	Wall base	2012	1,032	26	39	26		53	32
33	Compressor installation	2012	5,896	151	39	151		302	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 7,202,058	\$ 191,907		\$ 184,666	\$ (7,241)	\$ 328,142	34

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

Facility Name &amp; ID Number NILES NRSNG &amp; REHAB CENTER

# 0050088

Report Period Beginning:

1/1/13

Ending:

12/31/13

## 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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 7,202,058	\$ 191,907		\$ 184,666	\$ (7,241)	\$ 328,142	1
2	Compressor installation	2012	5,896	151	39	151		302	2
3	Power wash, paint and scape etire building	2012	15,950	409	39	409		818	3
4	Remove & install wall and delivery door	2012	1,300	33	39	33		67	4
5	Remove entire back patio, sidewalk	2012	16,000	410	39	410		820	5
6	Remove shrubbery by exit door	2012	775	20	39	20		40	6
7	Paint supplies	2012	1,237	32	39	32		63	7
8	Truck rental	2012	3,000	77	39	77		154	8
9	Repair, sand, prime, & paint walls, install new tiles	2012	860	22	39	22		44	9
10									10
11									11
12									12
13	Fire alarm system	6/28/2013	49,096	1,260	39	1,259	(1)	1,260	13
14	Sand/prime 3rd floor dining	3/16/2013	2,700	69	39	69		69	14
15	Prep/sand - dining room	3/22/2013	980	25	39	25		25	15
16	flooring - dementia unit	8/14/2013	980	25	39	25		25	16
17	flooring - dementia unit dining	8/15/2013	1,520	39	39	39		39	17
18	prep/sand flooring - bathrooms	11/15/2013	1,150	29	39	29		29	18
19	prep/sand flooring - bathrooms	11/15/2013	1,150	29	39	29		29	19
20	prep/sand flooring - bathrooms	12/6/2013	1,500	38	39	38		38	20
21	Emergency stop switch - 1st floor	5/29/2023	2,005	51	39	51		51	21
22	Sprinkler / ceiling - 2nd floor	3/29/2013	8,000	205	39	205		205	22
23	Sprinkler / ceiling - 2nd floor	10/31/2013	7,000	179	39	179		179	23
24	Generator	8/26/2013	7,165	184	39	184		184	24
25	Hot water heater	4/18/2013	58,850	1,510	39	1,509	(1)	1,510	25
26	Chiller	9/10/2013	1,958	50	39	50		50	26
27	Chiller - 2nd unit	9/20/2013	8,496	218	39	218		218	27
28	A/C condenser	9/17/2013	6,115	157	39	157		157	28
29	Walk in Cooler	1/29/2013	5,805	149	39	149		149	29
30	Motor for exhaust fan	8/8/2013	1,571	40	39	40		40	30
31	Fire pump & repair	10/16/2013	1,474	38	39	38		38	31
32	Sewer drainage - circular drive	8/22/2013	8,900	228	39	228		228	32
33	Pipes/handrails - Stairwell	12/19/2013	5,400	138	39	138		138	33
34	TOTAL (lines 1 thru 33)		\$ 7,428,891	\$ 197,722		\$ 190,479	\$ (7,243)	\$ 335,111	34

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

XI. OWNERSHIP COSTS (continued)

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

1	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	\$ 7,428,891	\$ 197,722		\$ 190,479	\$ (7,243)	\$ 335,111		1
2	Ashphalt driveway	8/23/2013	3,000	77	39	77		77	2
3	hinges/doors - North Stairway	11/14/2013	1,790	46	39	46		46	3
4	Fire door / oxygen room	12/8/2013	5,330	137	39	137		137	4
5	hinges/doors - business office	12/26/2013	(1,607)	(41)	39	(41)		(41)	5
6	Swing gate - 1st floor	12/15/2013	678	17	39	17		17	6
7	Doors/hinges - business office	12/19/2013	2,024	52	39	52		52	7
8									8
9	2008 Assets not allowed for increased capital reimbursement	2008	9,000	231	39	231		1,288	9
10	2009 Assets not allowed for increased capital reimbursement	2009	20,575	527	39	528	1	2,638	10
11	2010 Assets not allowed for increased capital reimbursement	2010	1,160	30	39	30		119	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 7,470,841	\$ 198,798		\$ 191,556	\$ (7,242)	\$ 339,444		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	\$ 1,039,354	\$ 128,591	\$ 206,435	\$ 77,844	5	\$ 462,475	71
72	Current Year Purchases	131,778	71,719	18,478	(53,241)	5	71,719	72
73	Fully Depreciated Assets							73
74								74
75	<b>TOTALS</b>	\$ 1,171,132	\$ 200,310	\$ 224,913	\$ 24,603		\$ 534,194	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	<b>TOTALS</b>			\$	\$	\$	\$		\$	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)	\$ 9,141,973	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 399,108	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 416,469	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 17,361	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 873,638	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	<b>TOTALS</b>	\$	\$	\$	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?

If NO, see instructions.  YES  NO

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

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. \_\_\_\_\_ /2014                      \$ \_\_\_\_\_

13. \_\_\_\_\_ /2015                      \$ \_\_\_\_\_

14. \_\_\_\_\_ /2016                      \$ \_\_\_\_\_

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

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number NILES NRSG & REHAB CENTER # 0050088 Report Period Beginning: 1/1/13 Ending: 12/31/13  
**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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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	<b>TOTALS</b>	\$	\$	\$	\$
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**

<b>COMPLETED</b>		
1. From this facility		
2. From other facilities (f)		
<b>DROP-OUTS</b>		
1. From this facility		
2. From other facilities (f)		
<b>TOTAL TRAINED</b>		

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10A-3	hrs	\$			\$ 322,484	\$		\$ 322,484	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs				201,183			201,183	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	10A-3	hrs				273,346			273,346	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					250,820		250,820	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Other (specify):										12
13	Other (specify): <b>RADIOLOGY/LAB/A</b>	39-3						11,905		11,905	13
14	<b>TOTAL</b>			\$			\$ 797,013	\$ 262,725		\$ 1,059,738	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number **NILES NRS&G & REHAB CENTER**

# **0050088**

Report Period Beginning: **1/1/13**

Ending: **12/31/13**

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **12/31/13** (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ (72,465)	\$ 64,830	1
2	Cash-Patient Deposits	(10,687)	(10,687)	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	5,388,512	5,388,512	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	152,394	152,394	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	<b>\$ 5,457,754</b>	<b>\$ 5,595,049</b>	<b>10</b>
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		500,000	13
14	Buildings, at Historical Cost		6,000,000	14
15	Leasehold Improvements, at Historical Cost	1,470,840	1,470,840	15
16	Equipment, at Historical Cost	563,132	1,171,132	16
17	Accumulated Depreciation (book methods)	(518,166)	(873,638)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		18,185,064	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(1,716,560)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spec reserves)		353,388	22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	<b>\$ 1,515,806</b>	<b>\$ 25,090,226</b>	<b>24</b>
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	<b>\$ 6,973,560</b>	<b>\$ 30,685,275</b>	<b>25</b>

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 1,402,950	\$ 1,576,799	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	606,455	606,455	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
<b>Other Current Liabilities(specify):</b>				
36	working capital	1,195,065	1,195,065	36
37	working capital	2,974,241	2,974,241	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	<b>\$ 6,178,711</b>	<b>\$ 6,352,560</b>	<b>38</b>
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		22,607,168	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	<b>\$</b>	<b>\$ 22,607,168</b>	<b>45</b>
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	<b>\$ 6,178,711</b>	<b>\$ 28,959,728</b>	<b>46</b>
47	<b>TOTAL EQUITY(page 18, line 24)</b>	<b>\$ 794,849</b>	<b>\$ 1,725,547</b>	<b>47</b>
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	<b>\$ 6,973,560</b>	<b>\$ 30,685,275</b>	<b>48</b>

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,146,473	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,146,473	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(872,665)	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) <u>Related Party Property Co. net income</u>	521,041	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (351,624)	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 794,849	24 *

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

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 16,317,633	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 16,317,633	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	299,357	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 299,357	8
<b>C. Other Operating Revenue</b>			
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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Related Party Property Co. Income</b>	2,940,000	28
28a	<b>Vending &amp; miscellaneous income</b>	63,701	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 3,003,701	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 19,620,691	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	2,515,010	31
32	Health Care	7,240,608	32
33	General Administration	2,495,390	33
<b>B. Capital Expense</b>			
34	Ownership	6,812,113	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	262,725	35
36	Provider Participation Fee	739,915	36
<b>D. Other Expenses (specify):</b>			
37	<u>bad debt exp</u>	427,595	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 20,493,356	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(872,665)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (872,665)	43

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 12,577,014	44
45	Private Pay - Net Inpatient Revenue	1,101,228	45
46	Medicare - Net Inpatient Revenue	2,502,767	46
47	Other-(specify)	136,624	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 16,317,633	49

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ 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.

Facility Name & ID Number **NILES NRSRG & REHAB CENTER**

# **0050088**

Report Period Beginning:

1/1/13

Ending:

12/31/13

**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,904	1,992	\$ 98,434	\$ 49.41	1
2	Assistant Director of Nursing	1,960	2,080	80,240	38.58	2
3	Registered Nurses	52,241	57,352	1,767,696	30.82	3
4	Licensed Practical Nurses	34,505	38,503	1,011,553	26.27	4
5	CNAs & Orderlies	152,216	168,986	2,292,945	13.57	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	20,836	23,218	343,032	14.77	9
10	Activity Assistants					10
11	Social Service Workers	9,264	9,892	188,588	19.06	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	37,035	41,185	546,509	13.27	15
16	Dishwashers					16
17	Maintenance Workers	5,570	6,300	100,554	15.96	17
18	Housekeepers	31,788	36,542	445,380	12.19	18
19	Laundry	7,322	8,157	103,394	12.68	19
20	Administrator	4,064	4,353	122,627	28.17	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,760	17,193	324,223	18.86	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	1,962	2,236	34,658	15.50	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	376,427	417,989	\$ 7,459,833 *	\$ 17.85	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	272	\$ 13,621	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	341	17,072	10-3	38
39	Pharmacist Consultant	529	26,452	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	271	13,546	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,414	\$ 70,691		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

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
JASON LEE	admin		\$ 38,000	Workers' Compensation Insurance	\$ 152,744	IDPH License Fee	\$ 1,990	
MICHAEL PERL	admin		84,627	Unemployment Compensation Insurance	58,976	Advertising: Employee Recruitment		
				FICA Taxes	604,936	Health Care Worker Background Check		
				Employee Health Insurance	356,504	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		illinois council	32,715	
				pension expense	64,625	village of niles	4,917	
				employee exp	68,853	fire marshall	680	
				uniforms	6,868	allscripts	1,625	
						various	2,030	
						Less: Public Relations Expense	( )	
						Non-allowable advertising	( )	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 122,627			TOTAL (agree to Sch. V,	\$ 43,957	
(List each licensed administrator separately.)				TOTAL (agree to Schedule V,	\$ 1,313,506	line 20, col. 8)		
				line 22, col.8)				
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
							auto allowance	31,943
							mileage	1,784
							Seminar Expense	
							education	1,834
							seminars	1,930
							Entertainment Expense	( )
							(agree to Sch. V,	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL		\$	line 24, col. 8)	\$ 37,491
(Attach a copy of any management service agreement)								
C. Professional Services								
Vendor/Payee	Type		Amount					
BRADLEY & ASSOCAITES	ACCOUNTING		\$ 9,144					
JOHNSON,GOLDBERG	ACCOUNTING		2,500					
sandra thiel	LEGAL		1,113					
ruben garcia	LEGAL		1,375					
CLARK HILL	LEGAL		1,100					
stirs	consulting fees		47,500					
INFINITY HEALTHCARE	MANAGEMENT SVC		315,310					
MTS CONSULTING	PROFESSIONAL FEES		488					
infinity funding	PROFESSIONAL FEES		6,205					
various	PROFESSIONAL FEES		12,525					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 397,260					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

\* Attach copy of IMRF notifications

\*\*See instructions.

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

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

Facility Name &amp; ID Number NILES NRSG &amp; REHAB CENTER

# 0050088

Report Period Beginning:

1/1/13

Ending:

12/31/13

## 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
- (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. \$ 87,444 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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 739,915  
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? NA  
Attach invoices and a summary of services for all architect and appraisal fees.