

Facility Name & ID Number NILES NRSG & REHAB CENTER

0050088 Report Period Beginning: 1/1/14 Ending: 12/31/14

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>43,892</u>	<u>1,166</u>	<u>10,107</u>	<u>55,165</u>	8
9	SNF/PED					9
10	ICF	<u>43,892</u>	<u>1,165</u>	<u>1,576</u>	<u>46,633</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>87,784</u>	<u>2,331</u>	<u>11,683</u>	<u>101,798</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.74%

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 8,531

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: 12/31/14 Fiscal Year: 12/31/14

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	548,967	693,851	12,635	1,255,453		1,255,453	1,065	1,256,518		1
2	Food Purchase		57,826		57,826		57,826		57,826		2
3	Housekeeping	472,976	64,589		537,565		537,565		537,565		3
4	Laundry	101,960	51,326		153,286		153,286		153,286		4
5	Heat and Other Utilities			366,776	366,776		366,776	1,133	367,909		5
6	Maintenance	115,345	67,497	113,688	296,530		296,530	(9)	296,521		6
7	Other (specify):*										7
8	TOTAL General Services	1,239,248	935,089	493,099	2,667,436		2,667,436	2,189	2,669,625		8
	B. Health Care and Programs										
9	Medical Director			22,200	22,200		22,200		22,200		9
10	Nursing and Medical Records	5,367,485	463,733	21,225	5,852,443		5,852,443	53,213	5,905,656		10
10a	Therapy			1,108,341	1,108,341		1,108,341		1,108,341		10a
11	Activities	336,451	56,253		392,704		392,704		392,704		11
12	Social Services	198,875		10,202	209,077		209,077		209,077		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Pharmacy Consultant			20,088	20,088		20,088		20,088		15
16	TOTAL Health Care and Programs	5,902,811	519,986	1,182,056	7,604,853		7,604,853	53,213	7,658,066		16
	C. General Administration										
17	Administrative	187,453			187,453		187,453		187,453		17
18	Directors Fees										18
19	Professional Services			745,095	745,095		745,095	(316,780)	428,315		19
20	Dues, Fees, Subscriptions & Promotions			28,544	28,544		28,544		28,544		20
21	Clerical & General Office Expenses	331,025	167,041	22,236	520,302		520,302	132,497	652,799		21
22	Employee Benefits & Payroll Taxes			1,516,265	1,516,265		1,516,265	35,424	1,551,689		22
23	Inservice Training & Education										23
24	Travel and Seminar			29,771	29,771		29,771	265	30,036		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			340,713	340,713		340,713	1,130	341,843		26
27	Other (specify):*										27
28	TOTAL General Administration	518,478	167,041	2,682,624	3,368,143		3,368,143	(147,464)	3,220,679		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,660,537	1,622,116	4,357,779	13,640,432		13,640,432	(92,062)	13,548,370		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:

1/1/14

Ending:

12/31/14

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	
	D. Ownership											
30	Depreciation			403,381	403,381		403,381	40,905	444,286			30
31	Amortization of Pre-Op. & Org.			1,212,336	1,212,336		1,212,336		1,212,336			31
32	Interest			1,660,107	1,660,107		1,660,107		1,660,107			32
33	Real Estate Taxes			544,774	544,774		544,774		544,774			33
34	Rent-Facility & Grounds			2,940,000	2,940,000		2,940,000	(2,922,233)	17,767			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			6,760,598	6,760,598		6,760,598	(2,881,328)	3,879,270			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		276,300		276,300		276,300		276,300			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			773,502	773,502		773,502		773,502			42
43	Other (specify):* Bad Debt			697,528	697,528		697,528	(697,528)				43
44	TOTAL Special Cost Centers		276,300	1,471,030	1,747,330		1,747,330	(697,528)	1,049,802			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,660,537	1,898,416	12,589,407	22,148,360		22,148,360	(3,670,918)	18,477,442			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		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	40,905	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				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	(697,528)	43		24
25	Fund Raising, Advertising and Promotional	(36,577)	21		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule various	(2,980,117)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (3,673,317)		\$	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)	2,399	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 2,399		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (3,670,918)		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					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

NILES NRSG & REHAB CENTER

ID# 0050088

Report Period Beginning: 1/1/14

Ending: 12/31/14

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Vending Income	\$ (2,487)	6	1
2	Miscellaneous Income	(37,630)	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	Total	(2,980,117)		49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

1/1/14

Ending:

12/31/14

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	1,065	0	0	0	0	0	0	0	0	0	1,065	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	1,133	0	0	0	0	0	0	0	0	0	1,133	5
6	Maintenance	(2,487)	2,478	0	0	0	0	0	0	0	0	0	(9)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,487)	4,676	0	2,189	8								
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	53,213	0	0	0	0	0	0	0	0	0	53,213	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	53,213	0	53,213	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	(316,780)	0	0	0	0	0	0	0	0	0	(316,780)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(74,207)	206,704	0	0	0	0	0	0	0	0	0	132,497	21
22	Employee Benefits & Payroll Taxes	0	35,424	0	0	0	0	0	0	0	0	0	35,424	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	265	0	0	0	0	0	0	0	0	0	265	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	1,130	0	0	0	0	0	0	0	0	0	1,130	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(74,207)	(73,257)	0	(147,464)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(76,694)	(15,368)	0	(92,062)	29								

STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

1/1/14

Ending:

12/31/14

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	40,905	0	0	0	0	0	0	0	0	0	0	40,905	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	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(2,940,000)	17,767	0	0	0	0	0	0	0	0	0	(2,922,233)	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	(2,899,095)	17,767	0	(2,881,328)	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):*	(697,528)	0	0	0	0	0	0	0	0	0	0	(697,528)	43
44	TOTAL Special Cost Centers	(697,528)	0	0	0	0	0	0	0	0	0	0	(697,528)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(3,673,317)	2,399	0	(3,670,918)	45								

VII. RELATED PARTIES

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

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

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1 DIETARY	\$ 12,636	INFINITY HEALTHCARE MANAGEMENT		\$ 13,701	\$ 1,065	1
2	V	2 RAW FOOD		INFINITY HEALTHCARE MANAGEMENT				2
3	V	5 UTILITIES		INFINITY HEALTHCARE MANAGEMENT		1,133	1,133	3
4	V	6 MAINTENANCE		INFINITY HEALTHCARE MANAGEMENT		2,478	2,478	4
5	V	10 NURSING	11,155	INFINITY HEALTHCARE MANAGEMENT		64,368	53,213	5
6	V	19 PROFESSIONAL FEES	323,948	INFINITY HEALTHCARE MANAGEMENT		7,168	(316,780)	6
7	V	21 OFFICE EXPENSE	18,343	INFINITY HEALTHCARE MANAGEMENT		225,047	206,704	7
8	V	32 INTEREST		INFINITY HEALTHCARE MANAGEMENT				8
9	V	24 TRAVEL	528	INFINITY HEALTHCARE MANAGEMENT		793	265	9
10	V	26 LIABILITY INSURANCE		INFINITY HEALTHCARE MANAGEMENT		1,130	1,130	10
11	V	34 RENT		INFINITY HEALTHCARE MANAGEMENT		17,767	17,767	11
12	V	22 EMPLOYEE BENEFITS	2,337	INFINITY HEALTHCARE MANAGEMENT		37,761	35,424	12
13	V							13
14	Total		\$ 368,947			\$ 371,346	\$ * 2,399	14

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

Facility Name & ID Number

NILES NRSG & REHAB CENTER

0050088

Report Period Beginning:

1/1/14

Ending:

12/31/14

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: 1/1/14 Ending: 12/31/14

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:

1/1/14

Ending: 12/31/14

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	TOTALS				\$	\$		\$	25

Facility Name & ID Number NILES NRSRG & REHAB CENTER

0050088

Report Period Beginning:

1/1/14

Ending:

12/31/14

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			
A. Directly Facility Related																	
Long-Term																	
1	hud loan		x	mortgage	\$94,399.00	8/26/14	\$ 22,000,000	\$ 21,923,915	9/1/49	3.1420	\$ 899,123						
2	loan interest										216,666						
3	finance charges										220,000						
4																	
5																	
Working Capital																	
6	capital one		x	working capital	none	08/31/2014	26,000,000	1,983,685	08/31/2018	2.9590	22,737						
7	infinity funding	x		working capital	none	various	various	475,000	various	various	301,581						
8																	
9	TOTAL Facility Related				\$94,399.00		\$ 48,000,000	\$ 24,382,600			\$ 1,660,107						
B. Non-Facility Related*																	
10																	
11																	
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$			\$						
15	TOTALS (line 9+line14)						\$ 48,000,000	\$ 24,382,600			\$ 1,660,107						

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																	
1. Real Estate Tax accrual used on 2013 report.		\$	(34,110)		1														
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	724,630		2														
3. Under or (over) accrual (line 2 minus line 1).		\$	758,740		3														
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	(213,966)		4														
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$			5														
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6														
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	544,774		7														
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2009	668,938	8	<table border="1"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2013 \$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td style="text-align: center;">16</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2013 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
FOR BHF USE ONLY																			
13	FROM R. E. TAX STATEMENT FOR 2013 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
	2010	613,791	9																
	2011	621,420	10																
	2012	610,192	11																
	2013	724,630	12																

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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME NILES NRSG & REHAB CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0050088

CONTACT PERSON REGARDING THIS REPORT Alan sorscher

TELEPHONE 708-449-1900 FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2013 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 2013.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>09-11-306-005-0000</u>	<u>NURSING FACILITY</u>	\$ <u>282,360.53</u>	\$ <u>282,360.53</u>
2. <u>09-11-306-006-0000</u>	<u>NURSING FACILITY</u>	\$ <u>282,262.93</u>	\$ <u>282,262.93</u>
3. <u>09-11-306-013-0000</u>	<u>NURSING FACILITY</u>	\$ <u>160,006.37</u>	\$ <u>160,006.37</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>724,629.83</u></u>	\$ <u><u>724,629.83</u></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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>NURSING HOME</u>		<u>2012</u>	<u>\$ 500,000</u>	1
2					2
3	TOTALS			\$ 500,000	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	304	2012		\$ 6,000,000	\$ 154,240	39	\$ 153,846	\$ (394)	\$ 379,426	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Signs		2008	271	7	39	7		46	9
10	Signs		2008	8,184	210	39	210		1,382	10
11	Sprinkler Installation		2008	2,305	59	39	59		389	11
12	Fire Alarm Repairs		2008	1,701	44	39	44		288	12
13	Install Sign		2008	8,315	213	39	213		1,404	13
14	Prep Work for Sign Install		2008	2,800	72	39	72		473	14
15	Smoke Damper		2008	2,150	55	39	55		363	15
16	Boiler Pump Maintenance		2008	1,106	28	39	28		186	16
17	A/C - Water Chiller		2008	1,164	30	39	30		197	17
18	A/C - Unit Repair		2008	970	25	39	25		164	18
19	Fire Dampers		2008	5,543	142	39	142		936	19
20	Fixed Boiler for Hot Water		2008	1,348	35	39	35		228	20
21	A/C Compressor		2008	12,764	327	39	327		2,154	21
22	Freezer Repairs		2008	980	25	39	25		165	22
23	New Motor for Heater, Fix Pump, Boiler		2008	5,493	141	39	141		928	23
24	Hot Water Heater Repairs		2008	908	23	39	23		153	24
25	Freezer Repairs		2008	1,030	26	39	26		173	25
26	Dish Installation - Cable		2008	9,000	231	39	231		1,519	26
27	Cleared Short - Elevator		2008	754	19	39	19		127	27
28	Replaced Shorting Bar		2008	347	9	39	9		59	28
29	New Button for Elevator		2008	618	16	39	16		104	29
30	New Relay for Elevator		2008	300	8	39	8		51	30
31	New Door Contractor for Elevator		2008	685	18	39	18		116	31
32	New Contractors/Relays for Elevator		2008	1,157	30	39	30		196	32
33	Elevator Hydraulic Packing		2008	1,400	36	39	36		236	33
34	Elevator Hydraulic Oil, Seals, Rings		2008	5,190	133	39	133		876	34
35	Laundry Room Door Installation		2008	1,430	37	39	37		242	35
36	3rd Floor Exit Door		2008	1,323	34	39	34		223	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number NILES NRSRG & REHAB CENTER

0050088

Report Period Beginning:

1/1/14

Ending:

12/31/14

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	\$	\$ 131	37
38	Door Replacement Parts	2008	940	24	39	24		159	38
39	Door Alarm Systems	2008	2,067	53	39	53		349	39
40	Door Control Service Electric Work	2008	828	21	39	21		140	40
41	Painting 2nd Floor	2009	4,250	109	39	109		654	41
42	Painting 2nd Floor	2009	3,700	95	39	95		569	42
43	Paint Doors	2009	800	21	39	21		124	43
44	Remodeling/Painting Supplies	2009	455	12	39	12		70	44
45	Painting	2009	3,500	90	39	90		539	45
46	Painting	2009	3,500	90	39	90		539	46
47	Painting	2009	3,900	100	39	100		600	47
48	Painting	2009	3,500	90	39	90		539	48
49	Painting	2009	3,900	100	39	100		600	49
50	Floor Tiles	2009	5,904	151	39	151		908	50
51	Kitchen Doors	2009	1,500	38	39	38		230	51
52	Removate Hallways	2009	6,000	154	39	154		923	52
53	Renovate Lobby Floors	2009	4,060	104	39	104		624	53
54									54
55	Fire Protection Sprinler Work	2009	45,518	1,167	39	1,167		7,003	55
56	Fire Protection Sprinler Work	2009	59,483	1,525	39	1,525		9,151	56
57	Install Exhaust Fan	2009	500	13	39	13		77	57
58	Relocate Drain Pipes	2009	2,525	65	39	65		389	58
59	Install Wiring & Pipes	2009	1,350	35	39	35		208	59
60	Install Wiring	2009	1,585	41	39	41		244	60
61	Install Windows	2009	1,300	33	39	33		200	61
62	Remove and Install New A/C	2009	38,840	996	39	996		5,975	62
63	A/C Installation	2009	2,392	61	39	61		368	63
64	A/C Installation	2009	2,200	56	39	56		338	64
65	Install Floor Tiles	2009	7,200	185	39	185		1,108	65
66	Furnishing of Signage	2009	2,218	57	39	57		341	66
67	Fire Sprinkler	2009	1,445	37	39	37		222	67
68	Painting	2009	3,500	90	39	90		539	68
69	Install Extra Insulation	2010	1,105	28	39	28		141	69
70	TOTAL (lines 4 thru 69)		\$ 6,299,975	\$ 161,934		\$ 161,540	\$ (394)	\$ 426,806	70

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

Facility Name & ID Number NILES NRSRG & REHAB CENTER

0050088

Report Period Beginning:

1/1/14

Ending:

12/31/14

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 12A, Carried Forward		\$ 6,299,975	\$ 161,934		\$ 161,540	\$ (394)	\$ 426,806	1
2	Remove and Replaced Existing Carpet Tile	2010	573	15	39	15		74	2
3	Grain Quarry Tile Materials and Freight	2010	797	20	39	20		102	3
4	Paint Nursing Station and Baseboards	2010	830	21	39	21		106	4
5	Freeyer Floor and Dishwasher Sink	2010	530	14	39	14		68	5
6	Patched/Painted Walls, Handrails, Double Doors	2010	3,200	82	39	82		410	6
7	Granite and Paint Supplies	2010	710	18	39	18		91	7
8	Painting on 3rd and 4th Floor	2010	1,635	42	39	42		210	8
9	Marble Tile and Labor	2010	1,000	26	39	26		129	9
10	Install Toilet Bowls	2010	327	8	39	8		42	10
11	Install Toilet Bowls	2010	327	8	39	8		42	11
12	Removed and Installed New Carpet	2010	1,500	38	39	38		192	12
13	Install New Kitchen Tiles	2010	1,174	30	39	30		150	13
14	Tuckpointing	2010	2,215	57	39	57		284	14
15	Paint	2010	1,887	48	39	48		242	15
16	Paint and Semi-Gloss	2010	661	17	39	17		85	16
17	Paint	2010	661	17	39	17		85	17
18	Paint and Primer	2010	818	21	39	21		105	18
19	Paint	2010	758	19	39	19		97	19
20	Painting & Wallpapering	2010	1,556	40	39	40		200	20
21	Replaced Compressor and Labor	2010	9,500	244	39	244		1,217	21
22	Install New High Pressure Sodium Light Fixture	2010	880	23	39	23		113	22
23	New Venolation Air Handler	2010	1,050	27	39	27		135	23
24	Repair & Replace Hot Gas Line	2010	6,050	155	39	155		775	24
25	Repair & Repave Sidewalks & Parking Lot	2010	30,390	779	39	779		3,895	25
26	Install New Showers and & Water system	2011	154,527	3,963	39	3,962	(1)	15,850	26
27	Replace Lighting	2011	1,185	30	39	30		121	27
28	Repair Main Electrical Distribution Box, Install New Outlets & Sw	2011	8,950	229	39	229		917	28
29	Fix Small Steamer and Mount Wire & Install Circulating A/C Pun	2011	4,230	108	39	108		433	29
30	Replace Compressor on Air Conditioning Chiller	2011	11,624	298	39	298		1,192	30
31	Replace Ignition Control On Boilers	2011	1,103	28	39	28		113	31
32	Repair & Seal Power Line Shaft & Remove Rust and Reapir Wall	2011	5,750	147	39	147		589	32
33	Modernize Two 5 Stop Passenger Elevators	2011	143,386	3,678	39	3,677	(1)	14,708	33
34	TOTAL (lines 1 thru 33)		\$ 6,699,759	\$ 172,184		\$ 171,788	\$ (396)	\$ 469,578	34

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

Facility Name & ID Number NILES NRSNG & REHAB CENTER

0050088

Report Period Beginning:

1/1/14

Ending:

12/31/14

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 6,699,759	\$ 172,184		\$ 171,788	\$ (396)	\$ 469,578	1
2	Modernize Two 5 Stop Passenger Elevators	2011	104,672	2,684	39	2,684		10,737	2
3	Paint & Materials for First Floor Renevations	2011	654	17	39	17		67	3
4	Install New Tile, Sand & Paint Walls, Replace Plumbing	2011	3,850	99	39	99		395	4
5	Install New Floor, Move Electrical Outlers, Install Chair Rail	2011	6,280	161	39	161		644	5
6	Install Sprinkler Heads in Laundry Room	2011	925	24	39	24		95	6
7	Recharge Antifreeze System/Change OS&Y Valve	2011	2,998	77	39	77		308	7
8	Retrofit Lights	2011	40,064	1,027	39	1,027		4,110	8
9	Recharge Antifreeze System, Refill Freon, Repair A/C	2011	34,518	885	39	885		3,540	9
10	Replace Doors & Locks	2011	517	13	39	13		53	10
11									11
12	Replace hot water risers, shower drains, p-traps	2012	6,000	154	39	154		462	12
13	Fire alarn system install	2012	3,000	77	39	77		231	13
14	Fire alarn system install	2012	2,800	72	39	72		216	14
15	Install sink drain 7 p-trap, patch floor	2012	2,200	56	39	56		169	15
16	Vinyl plank flooring	2012	3,086	79	39	79		237	16
17	Ceiling panels, padlocks, screws, motor & condensor wheels	2012	3,051	78	39	78		234	17
18	TV remotes, batteries, powerstrips, cable	2012	1,118	29	39	29		86	18
19	Vinyl cve base, outlet grounded powerstrip	2012	528	14	39	14		41	19
20	Vinyl cve base case	2012	349	9	39	9		27	20
21	Install sink drains w grades & p-trap, patch floor	2012	2,200	56	39	56		169	21
22		2012	1,098	28	39	28		84	22
23	Repair, sand, prime, & paint walls, install new tiles	2012	860	22	39	22		66	23
24	Repair, sand, prime, & paint walls, install new tiles	2012	860	22	39	22		66	24
25	Remove wall paper & molds, install tiles, repair & paint walls	2012	970	25	39	25		75	25
26	Remove wall paper & molds, repair & paint walls	2012	540	14	39	14		42	26
27	Paint, prime, sand	2012	540	14	39	14		42	27
28	Install wooden fence	2012	400	10	39	10		31	28
29	Paint wall	2012	270	7	39	7		21	29
30	Install exhaust fans & grills	2012	450	12	39	12		35	30
31	Remove molds, paint walls, install exhaust fans	2012	500	13	39	13		39	31
32	Compressor installation	2012	600	15	39	15		46	32
33	Replace core, dryer, refrigerant	2012	841	22	39	22		65	33
34	TOTAL (lines 1 thru 33)		\$ 6,926,497	\$ 177,999		\$ 177,603	\$ (396)	\$ 492,011	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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 6,926,497	\$ 177,999		\$ 177,603	\$ (396)	\$ 492,011	1
2	Installation of compressor	2012	750	19	39	19		57	2
3	Installation of compressor	2012	750	19	39	19		57	3
4	Prep, sand & paint walls, repair flooring, install new cove	2012	2,250	58	39	58		173	4
5	Take out old condensing unit	2012	1,250	32	39	32		96	5
6	Take out old flooring, install new flooring, paint walls	2012	1,350	35	39	35		104	6
7	Relace sinks, faucets & countertops	2012	900	23	39	23		69	7
8	Hoses, sprinklers, gas, pvc brushing, refrigerant cylinder	2012	549	14	39	14		42	8
9	Paint walls, install new flooring & cove base	2012	1,500	38	39	38		115	9
10	Remove old flooring, install new tiles, paint walls	2012	2,350	60	39	60		181	10
11	Paint walls, install new flooring & cove base	2012	2,700	69	39	69		207	11
12	Paint & supplies	2012	1,476	38	39	38		114	12
13	Paint & supplies	2012	2,072	53	39	53		159	13
14	Paint	2012	720	18	39	18		55	14
15	Paint walls, remove carpet, install new flooring	2012	850	22	39	22		66	15
16	Paint & supplies	2012	745	19	39	19		57	16
17	Paint walls, install new flooring & cove base	2012	1,500	38	39	38		115	17
18	paint wasll, treat mold, repair floors, install new floors	2012	1,800	46	39	46		138	18
19	Cut opening in ceiling for closet partitions	2012	2,100	54	39	54		162	19
20	Elevator pits	2012	5,300	136	39	136		408	20
21	Engineered drawings, hydraulic calculations, hvdraulic placards	2012	10,800	277	39	277		831	21
22	Spinkler system	2012	92,810	2,381	39	2,380	(1)	7,140	22
23	Masonry repairs, roof maintenance, sheet metal repairs	2012	85,100	2,183	39	2,182	(1)	6,547	23
24		2012	2,244	58	39	58		173	24
25		2012	450	12	39	12		35	25
26	Install double egress hallway doors	2012	3,645	93	39	93		280	26
27	Install shunt trip breaker for elevator	2012	3,489	89	39	89		268	27
28	Kitchen hot water boiler	2012	16,745	429	39	429		1,288	28
29	Domestic water heat exchanger pump	2012	2,975	76	39	76		229	29
30	Domestic regulating valve rebuid and repair	2012	2,568	66	39	66		198	30
31	Heating boiler replacement	2012	16,895	433	39	433		1,299	31
32	Wall base	2012	1,032	26	39	26		79	32
33	Compressor installation	2012	5,896	151	39	151		453	33
34	TOTAL (lines 1 thru 33)		\$ 7,202,058	\$ 185,064		\$ 184,666	\$ (398)	\$ 513,206	34

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

Facility Name & ID Number NILES NRSG & REHAB CENTER

0050088

Report Period Beginning:

1/1/14

Ending:

12/31/14

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	\$ 185,064		\$ 184,666	\$ (398)	\$ 513,206	1
2	Compressor installation	2012	5,896	151	39	151		453	2
3	Power wash, paint and scape etire building	2012	15,950	409	39	409		1,227	3
4	Remove & install wall and delivery door	2012	1,300	33	39	33		100	4
5	Remove entire back patio, sidewalk	2012	16,000	410	39	410		1,230	5
6	Remove shrubbery by exit door	2012	775	20	39	20		60	6
7	Paint supplies	2012	1,237	32	39	32		95	7
8	Truck rental	2012	3,000	77	39	77		231	8
9	Repair, sand, prime, & paint walls, install new tiles	2012	860	22	39	22		66	9
10									10
11	Items deleted in FY10 and before capital rate reconciliation	2010	30,735		39	788	788		11
12									12
13	Fox Valley Fire	2013	49,096	1,259	39	1,259		2,519	13
14	Danny Golmavo	2013	2,700	69	39	69		138	14
15	Danny Golmavo	2013	980	25	39	25		50	15
16	Danny Golmavo	2013	980	25	39	25		50	16
17	Danny Golmavo	2013	1,520	39	39	39		78	17
18	Danny Golmavo	2013	1,150	29	39	29		58	18
19	Danny Golmavo	2013	1,150	29	39	29		58	19
20	Danny Golmavo	2013	1,500	38	39	38		76	20
21	Carv Supply	2013	2,005	51	39	51		102	21
22	Nova Fire Protection	2013	8,000	205	39	205		410	22
23	Nova Fire Protection	2013	7,000	179	39	179		358	23
24	Champion roofing	2013	7,165	184	39	184		368	24
25	Precision Heating	2013	58,850	1,509	39	1,509		3,019	25
26	Precision Heating	2013	1,958	50	39	50		100	26
27	Precision Heating	2013	8,496	218	39	218		436	27
28	Precision Heating	2013	6,115	157	39	157		314	28
29	Precision Heating	2013	5,805	149	39	149		298	29
30	Precision Heating	2013	1,571	40	39	40		80	30
31	Protective Fire	2013	1,474	38	39	38		76	31
32	Al Tuckpointing	2013	8,900	228	39	228		456	32
33	Al Tuckpointing	2013	5,400	138	39	138		276	33
34	TOTAL (lines 1 thru 33)		\$ 7,459,626	\$ 190,877		\$ 191,267	\$ 390	\$ 525,988	34

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

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

0050088

Report Period Beginning:

1/1/14

Ending:

12/31/14

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 12E, Carried Forward		\$ 7,459,626	\$ 190,877		\$ 191,267	\$ 390	\$ 525,988	1
2	Fire Star Concrete	2013	3,000	77	39	77		154	2
3	Davilco Construction	2013	1,790	46	39	46		92	3
4	Davilco Construction	2013	5,330	137	39	137		274	4
5	Davilco Construction	2013	(1,607)	(41)	39	(41)		(82)	5
6	Davilco Construction	2013	678	17	39	17		34	6
7	Davilco Construction	2013	2,024	52	39	52		104	7
8									8
9	2008 Assets not allowed for increased capital reimbursement	2008	9,000	231	39	231		1,519	9
10	2009 Assets not allowed for increased capital reimbursement	2009	20,575	527	39	528	1	3,165	10
11	2010 Assets not allowed for increased capital reimbursement	2010	1,160	30	39	30		149	11
12									12
13	Engineer Drawings	2014	6,032	77	39	155	78	77	13
14	Shiels Straight Passage lever	2014	4,021	52	39	103	51	52	14
15	Seas Anchor Point Lav Fac	2014	2,973	38	39	76	38	38	15
16	Shiels Straight Passage lever	2014	1,349	17	39	35	18	17	16
17	Grab Bar Stainless Steel	2014	3,861	50	39	99	49	50	17
18	Grab Bar Stainless Steel	2014	4,170	53	39	107	54	53	18
19	Floor, Irrigation, Lighting, Harware, Tools, Paint	2014	2,882	37	39	74	37	37	19
20	Kitchen, Drywall, Grab Bars, Plaster, Sinks, Paint, Stairwell	2014	21,715	278	39	557	279	278	20
21	Install Delay Egress Door System on 2nd Floor	2014	5,397	69	39	138	69	69	21
22	Precision Heating	2014	1,623	21	39	42	21	21	22
23	Precision Heating	2014	3,500	45	39	90	45	45	23
24	Remove Lights, Repair Windows, Install New Floors	2014	1,700	22	39	44	22	22	24
25	150 Undersink Piping Protectors	2014	3,967	51	39	102	51	51	25
26	Fix Sprinkler System to Code	2014	4,928	63	39	126	63	63	26
27	Fox Valley Fire	2014	8,832	113	39	226	113	113	27
28	Superior Construction	2014	7,880	101	39	202	101	101	28
29	Fire Doors in Lobby & Kitchen	2014	2,582	33	39	66	33	33	29
30	Repair Vents for 4 Dryers	2014	3,500	45	39	90	45	45	30
31	Precision Heating	2014	3,792	49	39	97	48	49	31
32	Precision Heating	2014	1,850	24	39	47	23	24	32
33	Upgrade Fire System	2014	8,400	108	39	215	107	108	33
34	TOTAL (lines 1 thru 33)		\$ 7,606,530	\$ 193,299		\$ 195,035	\$ 1,736	\$ 532,743	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 7,606,530	\$ 193,299		\$ 195,035	\$ 1,736	\$ 532,743	1
2	Precision Heating	2014	12,312	158	39	316	158	158	2
3	Superior Construction	2014	3,241	42	39	83	41	42	3
4	Precision Heating	2014	28,650	367	39	735	368	367	4
5	Diesel Fire Pump Re-Routing Pipes	2014	3,689	47	39	95	48	47	5
6	Replace Hydraulic Piston	2014	8,640	111	39	222	111	111	6
7	GL Adjustment	2014	11,900	153	39	305	152	153	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	TOTAL (lines 1 thru 33)		\$ 7,674,962	\$ 194,177		\$ 196,791	\$ 2,614	\$ 533,621	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	\$ 1,171,132	\$ 142,860	\$ 234,226	\$ 91,366		\$ 677,054	71
72	Current Year Purchases	66,344	66,344	13,269	(53,075)		66,344	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,237,476	\$ 209,204	\$ 247,495	\$ 38,291		\$ 743,398	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 9,412,438	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 403,381	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 444,286	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 40,905	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,277,019	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

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. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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: 1/1/14 Ending: 12/31/14
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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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.

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5					
					Units	Cost				
1	Licensed Occupational Therapist	10A-3	hrs	\$		\$ 33,880	\$		\$ 33,880	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs			23,067			23,067	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs			1,051,394			1,051,394	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				259,535		259,535	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/A	39-2					16,765		16,765	13
14	TOTAL			\$		\$ 1,108,341	\$ 276,300	\$	\$ 1,384,641	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: **1/1/14**

Ending: **12/31/14**

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/14** (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ (169,357)	\$ (7,827)	1
2	Cash-Patient Deposits	7,871	7,871	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	5,473,967	5,473,967	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	647,469	647,469	6
7	Other Prepaid Expenses	7,264	7,264	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,967,214	\$ 6,128,744	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		500,000	13
14	Buildings, at Historical Cost		6,000,000	14
15	Leasehold Improvements, at Historical Cost	1,674,962	1,674,962	15
16	Equipment, at Historical Cost	629,476	1,237,476	16
17	Accumulated Depreciation (book methods)	(680,845)	(1,277,019)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		18,185,064	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(2,928,896)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):		358,339	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,623,593	\$ 23,749,926	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,590,807	\$ 29,878,670	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 2,569,153	\$ 2,743,003	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	778,536	778,536	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	working capital	475,000	475,000	36
37	working capital	1,983,685	1,983,685	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,806,374	\$ 5,980,224	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		21,923,915	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)	\$	\$ 21,923,915	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,806,374	\$ 27,904,139	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,784,433	\$ 1,974,531	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,590,807	\$ 29,878,670	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 794,849	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 794,849	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	177,984	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>	811,600	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 989,584	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,784,433	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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 18,998,852	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 18,998,852	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	347,376	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 347,376	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		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	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	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	related party property co income	2,940,000	28
28a	misc and vending income	40,116	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,980,116	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 22,326,344	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	2,667,436	31
32	Health Care	7,652,828	32
33	General Administration	3,320,168	33
B. Capital Expense			
34	Ownership	6,760,598	34
C. Ancillary Expense			
35	Special Cost Centers	276,300	35
36	Provider Participation Fee	773,502	36
D. Other Expenses (specify):			
37	bad debt	697,528	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 22,148,360	40
41	Income before Income Taxes (line 30 minus line 40)**	177,984	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 177,984	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 13,711,757	44
45	Private Pay - Net Inpatient Revenue	427,497	45
46	Medicare - Net Inpatient Revenue	4,077,098	46
47	Other-(specify)	782,500	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 18,998,852	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

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

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

0050088

Report Period Beginning:

1/1/14

Ending:

12/31/14

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	1,752	1,936	\$ 100,819	\$ 52.08	1
2	Assistant Director of Nursing	1,864	2,160	86,531	40.06	2
3	Registered Nurses	51,824	57,819	1,863,975	32.24	3
4	Licensed Practical Nurses	36,232	39,627	1,042,964	26.32	4
5	CNAs & Orderlies	149,752	165,796	2,225,605	13.42	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,662	4,032	122,068	30.27	9
10	Activity Assistants	14,251	15,658	214,383	13.69	10
11	Social Service Workers	10,684	12,039	198,875	16.52	11
12	Dietician					12
13	Food Service Supervisor	4,974	5,562	99,078	17.81	13
14	Head Cook					14
15	Cook Helpers/Assistants	32,727	35,926	449,889	12.52	15
16	Dishwashers					16
17	Maintenance Workers	6,095	6,947	115,345	16.60	17
18	Housekeepers	33,888	38,893	472,976	12.16	18
19	Laundry	7,127	8,429	101,960	12.10	19
20	Administrator	3,848	4,230	187,453	44.32	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,360	17,948	331,025	18.44	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	2,665	2,928	47,591	16.25	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	377,705	419,930	\$ 7,660,537 *	\$ 18.24	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	253	\$ 12,635	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	425	21,225	10-3	38
39	Pharmacist Consultant	402	20,088	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	204	10,202	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,283	\$ 64,150		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			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function				Description	Amount	Description	Amount	
Jason Lee	Administrator		\$ 61,496	Workers' Compensation Insurance	\$ 230,739	IDPH License Fee	\$		
Michael Perl	Administrator		31,547	Unemployment Compensation Insurance	63,730	Advertising: Employee Recruitment			
Ambreen Qureshi	Administrator		94,410	FICA Taxes	576,434	Health Care Worker Background Check			
				Employee Health Insurance	584,122	(Indicate # of checks performed _____)			
				Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		illinois council	23,083		
				pension	42,998	illinois dept of public health	3,980		
				employee expense	49,006				
				uniforms	4,660	various	1,481		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 187,453						
B. Administrative - Other									
Description			Amount						
			\$						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$						
C. Professional Services									
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
Bradley Associates	Accounting		\$ 190			\$	Out-of-State Travel	\$	
Johnson & Goldberg	Accounting		2,500						
Various	Accounting		4,491						
Infinity	Consulting		345,616				In-State Travel		
Beech Street Capital	Consulting		66,000				auto allowance	23,162	
Bock & Clark	Consulting		2,715				mileage	4,425	
Various	Consulting		149,468				continuing education	75	
Meyer Magence	Legal		19,561				Seminar Expense		
Polsinelli	Legal		113				seminars	2,374	
Allen A Lefkovitz	Legal		99,830						
Continental Casualty Co	Professional		25,000						
Various	Professional		29,611				Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 745,095	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$ 30,036	

* 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	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number NILES NRSG & REHAB CENTER

0050088

Report Period Beginning:

1/1/14

Ending:

12/31/14

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. \$ 76,516 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 773,502
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. N/A
- 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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees.