

		FOR BHF USE					

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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

I. IDPH Facility ID Number: 0004499

Facility Name: Bel-Wood Nursing Home

Address: 6701 West Plank Road Peoria 61604
 Number City Zip Code

County: Peoria

Telephone Number: 309-697-4541 **Fax #** 309-697-6622

HFS ID Number: 069-333-049-001

Date of Initial License for Current Owners: 11/30/68

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input checked="" type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input checked="" type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Joyce Harmon **Telephone Number:** 309-677-6233

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/06 to 12/31/06 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Patrick Ulrich</u>	
	(Title) <u>County Administrator</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) <u>see attached compilation report</u>	
	(Telephone) () _____ Fax # () _____	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bel-Wood Nursing Home

0004499 Report Period Beginning: 1/1/06 Ending: 12/31/06

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	300	Skilled (SNF)	300	109,500	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	300	TOTALS	300	109,500	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	14,006	6,060	6,695	26,761	8
9	SNF/PED					9
10	ICF	61,873	13,596		75,469	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	75,879	19,656	6,695	102,230	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.36%

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 11/30/1968

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

YES Date _____ NO

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

YES NO If YES, enter number of beds certified 50 and days of care provided 6,695

Medicare Intermediary National Government Services, Inc.

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

Facility Name & ID Number Bel-Wood Nursing Home # 0004499 Report Period Beginning: 1/1/06 Ending: 12/31/06

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	715,687	38,319	70	754,076		754,076		754,076		1
2	Food Purchase		553,860		553,860		553,860	(6,319)	547,541		2
3	Housekeeping	487,375	45,363	38,617	571,355		571,355		571,355		3
4	Laundry	132,991	30,644		163,635		163,635	(4,194)	159,441		4
5	Heat and Other Utilities			338,895	338,895		338,895		338,895		5
6	Maintenance	58,905	57,333	38,007	154,245		154,245	6,299	160,544		6
7	Other (specify):*										7
8	TOTAL General Services	1,394,958	725,519	415,589	2,536,066		2,536,066	(4,214)	2,531,852		8
	B. Health Care and Programs										
9	Medical Director			5,000	5,000		5,000		5,000		9
10	Nursing and Medical Records	5,221,397	648,327	1,082,115	6,951,839		6,951,839		6,951,839		10
10a	Therapy			285,710	285,710		285,710		285,710		10a
11	Activities	323,311	8,576	376	332,263		332,263		332,263		11
12	Social Services	87,241		254	87,495		87,495		87,495		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	5,631,949	656,903	1,373,455	7,662,307		7,662,307		7,662,307		16
	C. General Administration										
17	Administrative	91,574		186,080	277,654		277,654	(70,466)	207,188		17
18	Directors Fees							61,559	61,559		18
19	Professional Services			148,544	148,544		148,544	126,205	274,749		19
20	Dues, Fees, Subscriptions & Promotions			25,082	25,082		25,082	(14,931)	10,151		20
21	Clerical & General Office Expenses	214,900	6,842	45,035	266,777		266,777	122,211	388,988		21
22	Employee Benefits & Payroll Taxes			858,247	858,247		858,247	873,102	1,731,349		22
23	Inservice Training & Education			4,810	4,810		4,810		4,810		23
24	Travel and Seminar			5,406	5,406		5,406		5,406		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			93,705	93,705		93,705	16,706	110,411		26
27	Other (specify):* Bad Debt Expense and Medicaid Contribution			1,537,227	1,537,227		1,537,227	(234,619)	1,302,608		27
28	TOTAL General Administration	306,474	6,842	2,904,136	3,217,452		3,217,452	879,767	4,097,219		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,333,381	1,389,264	4,693,180	13,415,825		13,415,825	875,553	14,291,378		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Bel-Wood Nursing Home #0004499 Report Period Beginning: 1/1/06 Ending: 12/31/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			370,602	370,602	370,602		370,602			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			158,236	158,236	158,236	(6,269)	151,967			32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles										35
36	Other (specify):* Loss on Disposal			1,229	1,229	1,229		1,229			36
37	TOTAL Ownership			530,067	530,067	530,067	(6,269)	523,798			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			164,250	164,250	164,250		164,250			42
43	Other (specify):*										43
44	TOTAL Special Cost Centers			164,250	164,250	164,250		164,250			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,333,381	1,389,264	5,387,497	14,110,142	14,110,142	869,284	14,979,426			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bel-Wood Nursing Home

0004499

Report Period Beginning: 1/1/06

Ending: 12/31/06

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	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(6,319)	2		4
5	Telephone, TV & Radio in Resident Rooms	(12,563)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(4,194)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(6,269)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary	(55,504)	17		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	(19,811)	17		18
19	Entertainment	(4,829)	22		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	(234,619)	27		24
25	Fund Raising, Advertising and Promotional	(14,931)	20		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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (359,039)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	1,228,323		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 1,228,323		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 869,284		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					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

SEE ACCOUNTANTS' COMPILATION REPORT

Bel-Wood Nursing Home

ID# 0004499

Report Period Beginning: 1/1/06

Ending: 12/31/06

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
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
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	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Bel-Wood Nursing Home

0004499

Report Period Beginning:

1/1/06

Ending:

12/31/06

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	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(6,319)	0	0	0	0	0	0	0	0	0	0	(6,319)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(4,194)	0	0	0	0	0	0	0	0	0	0	(4,194)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	6,299	0	0	0	0	0	0	0	0	0	6,299	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(10,513)	6,299	0	(4,214)	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	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(75,315)	4,849	0	0	0	0	0	0	0	0	0	(70,466)	17
18	Directors Fees	0	61,559	0	0	0	0	0	0	0	0	0	61,559	18
19	Professional Services	0	126,205	0	0	0	0	0	0	0	0	0	126,205	19
20	Fees, Subscriptions & Promotions	(14,931)	0	0	0	0	0	0	0	0	0	0	(14,931)	20
21	Clerical & General Office Expenses	(12,563)	134,774	0	0	0	0	0	0	0	0	0	122,211	21
22	Employee Benefits & Payroll Taxes	(4,829)	877,931	0	0	0	0	0	0	0	0	0	873,102	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	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	16,706	0	0	0	0	0	0	0	0	0	16,706	26
27	Other (specify):*	(234,619)	0	0	0	0	0	0	0	0	0	0	(234,619)	27
28	TOTAL General Administration	(342,257)	1,222,024	0	879,767	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(352,770)	1,228,323	0	875,553	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Bel-Wood Nursing Home# 0004499

Report Period Beginning:

1/1/06

Ending:

12/31/06

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	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,269)	0	0	0	0	0	0	0	0	0	0	(6,269)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	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	(6,269)	0	0	0	0	0	0	0	0	0	0	(6,269)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(359,039)	1,228,323	0	869,284	45								

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Peoria County	100%					

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	6 Facilities Management	\$	Peoria County	100.00%	\$ 6,299	\$ 6,299	1
2	V	17 Management Fee	140,355	Peoria County	100.00%	145,204	4,849	2
3	V	18 County Board		Peoria County	100.00%	61,559	61,559	3
4	V	19 Professional Services	137,879	Peoria County	100.00%	264,084	126,205	4
5	V	21 Clerical Services		Peoria County	100.00%	134,774	134,774	5
6	V	22 Employee Benefits-Health	704,405	Peoria County	100.00%	412,605	(291,800)	6
7	V	26 Liability Insurance	93,705	Peoria County	100.00%	110,411	16,706	7
8	V	22 IMRF		Peoria County	100.00%	594,142	594,142	8
9	V	22 FICA		Peoria County	100.00%	550,107	550,107	9
10	V	22 Employee Benefits-WC	99,928	Peoria County	100.00%	117,744	17,816	10
11	V	22 Employee Benefits-UC	42,995	Peoria County	100.00%	50,661	7,666	11
12	V							12
13	V							13
14	Total		\$ 1,219,267			\$ 2,447,590	\$ * 1,228,323	14

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

Facility Name & ID Number Bel-Wood Nursing Home # 0004499 Report Period Beginning: 1/1/06 Ending: 12/31/06

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	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bel-Wood Nursing Home

0004499

Report Period Beginning:

1/1/06

Ending: 12/31/06

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 Peoria County
 Street Address Rm 501, Peoria County Courthouse
 City / State / Zip Code Peoria, IL 61602
 Phone Number (309-672-6056
 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	6	Facilities Management			\$	\$		\$ 6,299	1
2	18	County Board						61,559	2
3	19	Professional Services						264,084	3
4	21	Clerical Services						134,774	4
5	22	Employee Benefits-Health						412,605	5
6	26	Liability Insurance						110,411	6
7	22	Employee Benefits-WC						117,744	7
8	22	Employee Benefits-UC						50,661	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				\$	\$		\$ 1,158,137	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										1										
2										2										
3										3										
4										4										
5										5										
Working Capital																				
6	Peoria County, Illinois	X		Operations	none	n/a		2,294,357	none	variable	158,236	6								
7												7								
8												8								
9	TOTAL Facility Related						\$	2,294,357			\$	158,236	9							
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$				\$		14							
15	TOTALS (line 9+line14)						\$	2,294,357			\$	158,236	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ none Line # _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Bel-Wood Nursing Home COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0004499

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE (____) _____ FAX #: (____) _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(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. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

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 _____ NO

If YES, attach an explanation & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

Facility Name & ID Number Bel-Wood Nursing Home

0004499

Report Period Beginning:

1/1/06

Ending:

12/31/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 115,800 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>	<u>8 acres</u>	<u>1848</u>	<u>\$ 100</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	#VALUE!		\$ 100	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bel-Wood Nursing Home

0004499

Report Period Beginning:

1/1/06

Ending:

12/31/06

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	300		1969	1969	\$ 3,123,273	\$ 62,465	50	\$ 62,465		\$ 2,373,682	4
5			1975	1975	4,223	94	45	94		3,005	5
6			1986	1986	47,151		various			47,151	6
7											7
8											8
	Improvement Type**										
9	Improvements		1978	1978	10,851	271	40	271		7,885	9
10	Improvements		1979	1979	23,127		20-25			23,127	10
11	Improvements		1980	1980	115,619		20-25			115,619	11
12	Improvements		1984	1984	18,571		various			18,571	12
13	Improvements		1985	1985	511,366		various			511,366	13
14	Improvements		1986	1986	48,090	593	20	593		48,090	14
15	Improvements		1987	1987	4,741		various			4,741	15
16	Improvements		1988	1988	104,423	4,726	various	4,726		97,235	16
17	Improvements		1989	1989	163,050	7,926	various	7,926		147,390	17
18	Improvements		1990	1990	140,837		various			140,837	18
19	Improvements		1991	1991	1,057,735	51,643	various	51,643		813,328	19
20	Improvements		1992	1992	191,871	10,229	various	10,229		152,472	20
21	Improvements		1995	1995	7,608	414	16-20	414		4,658	21
22	Building Improvements		1995	1995	24,473	1,675	5-20	1,675		17,944	22
23	Resurface Driveway		1996	1996	2,947	184	16	184		1,748	23
24	Roof Repairs - Massey		2005	2005	15,793	1,579	10	1,579		1,711	24
25	Draperies		1996	1996	1,218	80	10	80		1,218	25
26	Smoke Detector		2005	2005	1,710	171	10	171		328	26
27	4 Plexiglass Flower Boxes		2005	2005	1,580	316	5	316		606	27
28	Telephone Wiring		1996	1996	2,383	119	20	119		1,111	28
29	Draperies		1996	1996	2,691	269	10	269		2,511	29
30	Domestic Hot Water Temp Valve		2005	2005	2,082	416	5	416		798	30
31	Carpeting		2005	2005	7,333	1,467	5	1,467		2,445	31
32	Faucets		1997	1997	1,862	93	20	93		845	32
33	Replace Floor		1997	1997	1,035	52	20	52		472	33
34	Reception Area Shades		2004	2004	2,062	412	5	412		1,202	34
35	Addition to watermain		2004	2004	30,505	1,271	24	1,271		3,495	35
36	Door Closer and Locks		2004	2004	2,366	237	10	237		651	36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bel-Wood Nursing Home

0004499

Report Period Beginning:

1/1/06

Ending:

12/31/06

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Motor	1997	\$ 1,022	\$ 102	10	\$ 102	\$	\$ 918	37
38	Remodeling	1997	1,291	65	20	65		617	38
39	Door Replacement	1997	4,957	248	20	248		2,439	39
40	Ceiling tile	1997	1,488	99	15	99		965	40
41	Concrete Slabs	1997	825	41	20	41		393	41
42	Roof Repairs	2006	19,515	3,252	3	3,252		3,252	42
43	Sinks	1997	3,718	186	20	186		1,751	43
44	Plumbing	1997	2,397	96	25	96		904	44
45	Lights	1997	9,479	527	18	527		3,598	45
46	Compressor	1997	5,680	379	15	379		3,537	46
47	Wire	1997	337	17	20	17		156	47
48	HVAC Repairs	2006	52,475	8,746	3	8,746		8,746	48
49	Compressor Repairs	2004	10,589	2,118	5	2,118		4,236	49
50	Fireplace	1998	946	47	20	47		400	50
51	Water Pressur Pump	1998	2,226	223	10	223		1,877	51
52	Bi-fold Doors	1998	27,343	2,734	10	2,734		21,872	52
53	Sink System	1998	2,569	128	20	128		1,110	53
54	Handrails	1998	1,955	196	10	196		1,666	54
55	Water Softener	1998	34,106	2,842	12	2,842		23,683	55
56	Wire	1998	659	33	20	33		283	56
57	Roof Repair	1998	3,760	376	10	376		3,227	57
58	Draperies	1998	874	58	15	58		474	58
59	Engine Control Panel	2005	35,025	1,751	20	1,751		2,919	59
60	Door closers and locks	2005	899	90	10	90		97	60
61	Covebase	1998	353	24	15	24		204	61
62	Carpeting	2005	1,735	347	5	347		607	62
63	Wallpaper	1998	985	49	20	49		421	63
64	Wallpaper	1998	1,885	94	20	94		815	64
65	Wallpaper	1998	1,075	54	20	54		472	65
66	Wallpaper	1998	434	22	20	22		183	66
67	Roof Repairs	1998	3,467	347	10	347		2,776	67
68	Draperies	1998	1,872	125	15	125		1,000	68
69	Underground Storage Tank	1998	26,041	651	40	651		5,859	69
70	TOTAL (lines 4 thru 69)		\$ 5,934,558	\$ 172,768		\$ 172,768	\$	\$ 4,647,699	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Bel-Wood Nursing Home

0004499

Report Period Beginning:

1/1/06

Ending:

12/31/06

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,934,558	\$ 172,768		\$ 172,768	\$	\$ 4,647,699	1
2	Energy management system modifications	1999	3,732	373	10	373		2,860	2
3	Curtains	1999	797	80	10	80		606	3
4	Roof Repairs	1999	1,254	84	15	84		630	4
5	Shelving, dish room	2000	1,500	75	20	75		506	5
6	Door relocation	2000	1,461	73	20	73		487	6
7	Roof Repairs	2000	3,552	237	15	237		1,560	7
8	Water Main #1	2000	3,178	127	25	127		826	8
9	Housing Assembly	2000	874	87	10	87		566	9
10	Sidewalk Replacement	2000	1,350	68	20	68		442	10
11	Draperies	2000	4,839	484	10	484		3,106	11
12	Water Main #2	2000	2,120	85	25	85		538	12
13	Draperies	2000	728	73	10	73		456	13
14	Door guards	2000	1,694	85	20	85		531	14
15	Door, magnetic lock	2000	4,062	203	20	203		1,252	15
16	Replacement glass	2001	2,971	149	20	149		881	16
17	Fire system	2001	496	62	8	62		362	17
18	Water heater replacement	2001	84,666	10,583	8	10,583		60,606	18
19	Drawer front machine	2001	1,690	113	15	113		650	19
20	Paint	2001	5,028	334	5	334		5,028	20
21	HVAC Repairs	2005	103,550	20,710	5	20,710		31,065	21
22	Windows	2002	59,439	2,972	20	2,972		12,631	22
23	Resident Alarm System	2002	43,538	2,177	20	2,177		8,889	23
24	Exit Device	2002	1,862	186	10	186		744	24
25	Egress Bars for doors	2002	2,630	263	10	263		1,074	25
26	Rooftop Unit Pilot Program Phse 1	2002	1,420	95	15	95		380	26
27	Construction Documents	2002	6,750	844	8	844		3,376	27
28	Control Wiring	2002	2,495	125	20	125		573	28
29	Roof Repairs	2002	1,642	109	15	109		518	29
30	Architect fees per IDPA review of 1999 cost report	1999	15,290	1,911	8	1,911		7,644	30
31	Exit Signs	2003	2,596	260	10	260		1,018	31
32	Air Cylinder - Drain	2003	1,049	105	10	105		385	32
33	Zone Motor & Bases	2003	4,211	421	10	421		1,403	33
34	TOTAL (lines 1 thru 33)		\$ 6,307,022	\$ 216,321		\$ 216,321	\$	\$ 4,799,292	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Bel-Wood Nursing Home

0004499

Report Period Beginning:

1/1/06

Ending:

12/31/06

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 6,307,022	\$ 216,321		\$ 216,321	\$	\$ 4,799,292	1
2	Construction Documentation	2003	12,854	1,607	8	1,607		5,223	2
3	Fence for Alzheimer Unit	2003	4,277	285	15	285		926	3
4	Parking lot overlay	2003	39,414	2,463	16	2,463		8,005	4
5	Water heater replacement	2003	52,500	3,500	15	3,500		11,375	5
6	Engineering	2003	3,700	463	8	463		1,466	6
7	Water main replacement	2003	80,810	3,232	25	3,232		9,965	7
8	Fire alarm panel replacement	2003	22,710	1,136	20	1,136		3,503	8
9	Reception Area Remodel	2003	2,904	145	20	145		435	9
10	Double Egress Doors	2004	2,585	259	10	259		647	10
11	Alzheimer Security	2004	26,381	5,276	5	5,276		12,750	11
12	Wallpaper HC & Norwood	2004	3,237	647	5	647		1,564	12
13	Water heater replacement	2005	1,204	240	5	240		340	13
14	Blinds HC & Glasford	2004	6,070	1,214	5	1,214		2,934	14
15	Fire Alarm system	2004	111,652	11,165	10	11,165		26,052	15
16	Aluminum Awning	2004	1,726	173	10	173		389	16
17	Roof Repairs	2004	3,383	338	10	338		704	17
18	Electrical Service	2004	3,132	313	10	313		652	18
19	Fire Alarm Wiring	2004	5,812	581	10	581		1,162	19
20	Sink Repairs	2005	5,514	1,103	5	1,103		1,471	20
21	AA D379 Engine Repair	2005	1,300	260	5	260		520	21
22	Front Door Repair	2005	1,235	247	5	247		412	22
23	Carpeting	2005	1,563	313	5	313		443	23
24	C-wing Faux Wood Blinds	2005	4,998	1,000	5	1,000		1,500	24
25	Water Softener Overhaul	2005	1,574	315	5	315		472	25
26	Booster Pump	2006	4,000	67	5	67		67	26
27	Doors and Locks	2006	8,760	146	5	146		146	27
28	Door Latch Replacement	2006	28,360	4,727	5	4,727		4,727	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,748,677	\$ 257,537		\$ 257,537	\$	\$ 4,897,142	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Bel-Wood Nursing Home # 0004499 Report Period Beginning: 1/1/06 Ending: 12/31/06

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 816,867	\$ 98,047	\$ 98,047	\$	5-20	\$ 455,124	71
72	Current Year Purchases	69,954	11,436	11,436		5	11,436	72
73	Fully Depreciated Assets	185,382	1,833	1,833		5-20	185,382	73
74								74
75	TOTALS	\$ 1,072,203	\$ 111,316	\$ 111,316	\$		\$ 651,942	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Maintenance	2001 Dodge Ram Truck	2000	\$ 13,998	\$ 1,749	\$ 1,749	\$	8	\$ 11,519	76
77	Resident	1997 Ford El Dorado	1997	42,701				4	42,701	77
78										78
79										79
80	TOTALS			\$ 56,699	\$ 1,749	\$ 1,749	\$		\$ 54,220	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)	\$ 7,877,679	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 370,602	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 370,602	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,603,304	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.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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 Bel-Wood Nursing Home # 0004499 Report Period Beginning: 1/1/06 Ending: 12/31/06

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 <u>n/a</u></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 <u>n/a</u></p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bel-Wood Nursing Home# 0004499Report Period Beginning: 1/1/06

Ending:

12/31/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/06

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 8,324	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>430,000</u>)	2,857,543		3
4	Supply Inventory (priced at <u>cost</u>)	85,457		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	20,753		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,972,077	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	100		13
14	Buildings, at Historical Cost	6,516,880		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,128,902		16
17	Accumulated Depreciation (book methods)	(5,330,803)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,315,079	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,287,156	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,438,061	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	627,927		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	<u>Due to other funds</u>	2,294,357		36
37	<u>Deferred revenue</u>	139,989		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,500,334	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,500,334	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 786,822	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,287,156	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (404,960)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (404,960)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,256,082	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>dif in method used in acctng for payroll</u>	(27,190)	15
16	Other (describe) <u>dif in method used for depreciation</u>	(37,110)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,191,782	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)	\$ 786,822	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bel-Wood Nursing Home# 0004499Report Period Beginning: 1/1/06Ending: 12/31/06**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 15,236,082	1
2	Discounts and Allowances for all Levels	(2,144,579)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 13,091,503	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	426,899	6
7	Oxygen	80,721	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 507,620	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants	1,562,978	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	6,319	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	176,225	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	4,194	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,749,716	23
D. Non-Operating Revenue			
24	Contributions	1,660	24
25	Interest and Other Investment Income***	6,269	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 7,929	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	vending income	8,849	28
28a	miscellaneous	607	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 9,456	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 15,366,224	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,536,066	31
32	Health Care	7,662,307	32
33	General Administration	3,217,452	33
B. Capital Expense			
34	Ownership	530,067	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	164,250	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,110,142	40
41	Income before Income Taxes (line 30 minus line 40)**	1,256,082	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,256,082	43

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

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

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

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

Facility Name & ID Number Bel-Wood Nursing Home

0004499

Report Period Beginning:

1/1/06

Ending:

12/31/06

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,170	2,720	\$ 92,737	\$ 34.09	1
2	Assistant Director of Nursing	2,185	2,711	68,070	25.11	2
3	Registered Nurses	12,814	14,892	378,473	25.41	3
4	Licensed Practical Nurses	47,448	52,091	1,005,439	19.30	4
5	CNAs & Orderlies	252,321	287,609	3,601,371	12.52	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,848	2,198	65,869	29.97	9
10	Activity Assistants	11,199	13,457	257,442	19.13	10
11	Social Service Workers	3,636	4,339	87,241	20.11	11
12	Dietician					12
13	Food Service Supervisor	1,829	2,082	55,304	26.56	13
14	Head Cook	1,984	2,291	47,997	20.95	14
15	Cook Helpers/Assistants	48,659	54,315	612,386	11.27	15
16	Dishwashers					16
17	Maintenance Workers	4,177	4,480	58,905	13.15	17
18	Housekeepers	37,400	41,570	487,375	11.72	18
19	Laundry	9,851	10,937	132,991	12.16	19
20	Administrator	716	2,032	91,574	45.07	20
21	Assistant Administrator					21
22	Other Administrative	8,216	9,984	129,791	13.00	22
23	Office Manager					23
24	Clerical	6,553	9,396	85,109	9.06	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	3,995	4,396	75,307	17.13	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	457,001	521,500	\$ 7,333,381 *	\$ 14.06	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director		5,000	L9-C3	36
37	Medical Records Consultant		1,930	L10-C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant		145,514	L10a-C3	40
41	Occupational Therapy Consultant		116,885	L10a-C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant		23,310	L10a-C3	43
44	Activity Consultant		376	L11-C3	44
45	Social Service Consultant		254	L12-C3	45
46	Other(specify)				46
47	Medicare Consultant		1,750	L10-C3	47
48	Management Consultant		25,368	L17-C3	48
49	TOTAL (lines 35 - 48)		\$ 320,387		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	2,559	\$ 87,136	L10-C3	50
51	Licensed Practical Nurses	27,464	869,627	L10-C3	51
52	Certified Nurse Assistants/Aides	1,494	26,585	L10-C3	52
53	TOTAL (lines 50 - 52)	31,517	\$ 983,348		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bel-Wood Nursing Home

Report Period Beginning: 1/1/06 Ending:

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bel-Wood Nursing Home

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. County Nursing Home Assoc. \$2,850
- (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? _____
- (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? 5.0
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 108,990 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 164,250
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? Yes Indicate the amount. \$ 6,319
- (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. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Clifton Gunderson LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit in progress
- (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 \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT