

		FOR BHF USE					

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**2007**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2007)**

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

**I. IDPH License ID Number:** 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
<b>IRS Exemption Code</b> _____	<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 1/1/07 to 12/13/07 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.

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Matt Nieu Kirk</u>	
	(Title) <u>Executive Director</u>	
<b>Paid Preparer</b>	(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: 1/1/07 Ending: 12/13/07

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	18,107	4,788	7,630	30,525	8
9	SNF/PED					9
10	ICF	56,246	10,817		67,063	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	74,353	15,605	7,630	97,588	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.12%

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 7,630

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: 12/31/07 Fiscal Year: 12/31/07

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

Facility Name & ID Number Bel-Wood Nursing Home # 0004499 Report Period Beginning: 1/1/07 Ending: 12/13/07

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	717,464	32,982		750,446		750,446		750,446		1
2	Food Purchase		550,641		550,641		550,641	(4,722)	545,919		2
3	Housekeeping	520,279	49,145	27,442	596,866		596,866		596,866		3
4	Laundry	135,986	31,002		166,988		166,988	(4,194)	162,794		4
5	Heat and Other Utilities			399,757	399,757		399,757		399,757		5
6	Maintenance	92,189	32,899	52,570	177,658		177,658	6,299	183,957		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>1,465,918</b>	<b>696,669</b>	<b>479,769</b>	<b>2,642,356</b>		<b>2,642,356</b>	<b>(2,617)</b>	<b>2,639,739</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			5,000	5,000		5,000		5,000		9
10	Nursing and Medical Records	5,474,068	760,946	1,302,060	7,537,074		7,537,074		7,537,074		10
10a	Therapy			674,367	674,367		674,367		674,367		10a
11	Activities	300,712	28,607	497	329,816		329,816		329,816		11
12	Social Services	89,054		541	89,595		89,595		89,595		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>5,863,834</b>	<b>789,553</b>	<b>1,982,465</b>	<b>8,635,852</b>		<b>8,635,852</b>		<b>8,635,852</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	75,280		287,868	363,148		363,148	(39,761)	323,387		17
18	Directors Fees							61,559	61,559		18
19	Professional Services			153,366	153,366		153,366	126,205	279,571		19
20	Dues, Fees, Subscriptions & Promotions			54,611	54,611		54,611	(31,905)	22,706		20
21	Clerical & General Office Expenses	215,282	12,745	50,678	278,705		278,705	122,206	400,911		21
22	Employee Benefits & Payroll Taxes			936,024	936,024		936,024	902,219	1,838,243		22
23	Inservice Training & Education			864	864		864		864		23
24	Travel and Seminar			5,410	5,410		5,410		5,410		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			19,271	19,271		19,271	91,140	110,411		26
27	Other (specify):* <b>Bad Debt Expense and Medicaid Contribution</b>			4,106,527	4,106,527		4,106,527	(82,202)	4,024,325		27
28	<b>TOTAL General Administration</b>	<b>290,562</b>	<b>12,745</b>	<b>5,614,619</b>	<b>5,917,926</b>		<b>5,917,926</b>	<b>1,149,461</b>	<b>7,067,387</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>7,620,314</b>	<b>1,498,967</b>	<b>8,076,853</b>	<b>17,196,134</b>		<b>17,196,134</b>	<b>1,146,844</b>	<b>18,342,978</b>		<b>29</b>

\*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: 1/1/07 Ending: 12/13/07

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			373,807	373,807	373,807		373,807			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			101,538	101,538	101,538	(30,067)	71,471			32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles										35
36	Other (specify):* <b>Loss on Disposal</b>			7,991	7,991	7,991		7,991			36
37	<b>TOTAL Ownership</b>			483,336	483,336	483,336	(30,067)	453,269			37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
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	<b>TOTAL Special Cost Centers</b>			164,250	164,250	164,250		164,250			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	7,620,314	1,498,967	8,724,439	17,843,720	17,843,720	1,116,777	18,960,497			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: 1/1/07

Ending: 12/13/07

**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	(4,722)	2		4
5	Telephone, TV & Radio in Resident Rooms	(12,568)	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	(30,067)	32		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	(13,585)	17		18
19	Entertainment	(1,585)	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	(82,202)	27		24
25	Fund Raising, Advertising and Promotional	(31,905)	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	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (180,828)		\$	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)	1,297,605		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 1,297,605		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ 1,116,777		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Bel-Wood Nursing Home

ID# 0004499

Report Period Beginning: 1/1/07

Ending: 12/13/07

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	<b>Total</b>	0	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Bel-Wood Nursing Home

# 0004499

Report Period Beginning:

1/1/07

Ending:

12/13/07

## 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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,722)	0	0	0	0	0	0	0	0	0	0	(4,722)	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	<b>TOTAL General Services</b>	<b>(8,916)</b>	<b>6,299</b>	<b>0</b>	<b>(2,617)</b>	<b>8</b>								
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	(13,585)	(26,176)	0	0	0	0	0	0	0	0	0	(39,761)	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	(31,905)	0	0	0	0	0	0	0	0	0	0	(31,905)	20
21	Clerical & General Office Expenses	(12,568)	134,774	0	0	0	0	0	0	0	0	0	122,206	21
22	Employee Benefits & Payroll Taxes	(1,585)	903,804	0	0	0	0	0	0	0	0	0	902,219	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	91,140	0	0	0	0	0	0	0	0	0	91,140	26
27	Other (specify):*	(82,202)	0	0	0	0	0	0	0	0	0	0	(82,202)	27
28	<b>TOTAL General Administration</b>	<b>(141,845)</b>	<b>1,291,306</b>	<b>0</b>	<b>1,149,461</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(150,761)</b>	<b>1,297,605</b>	<b>0</b>	<b>1,146,844</b>	<b>29</b>								

STATE OF ILLINOIS

Facility Name & ID Number Bel-Wood Nursing Home

# 0004499

Report Period Beginning:

1/1/07

Ending:

Summary B

12/13/07

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
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	(30,067)	0	0	0	0	0	0	0	0	0	0	(30,067)	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	<b>TOTAL Ownership</b>	<b>(30,067)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(30,067)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> <b>(sum of lines 29, 37 &amp; 44)</b>	<b>(180,828)</b>	<b>1,297,605</b>	<b>0</b>	<b>1,116,777</b>	<b>45</b>								

**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	182,606	Peoria County	100.00%	156,430	(26,176)	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	728,515	Peoria County	100.00%	436,716	(291,799)	6
7	V	26 Liability Insurance	19,271	Peoria County	100.00%	110,411	91,140	7
8	V	22 IMRF		Peoria County	100.00%	657,754	657,754	8
9	V	22 FICA		Peoria County	100.00%	573,976	573,976	9
10	V	22 Employee Benefits- WC	194,282	Peoria County	100.00%	117,744	(76,538)	10
11	V	22 Employee Benefits-UC	10,250	Peoria County	100.00%	50,661	40,411	11
12	V							12
13	V							13
14	Total		\$ 1,272,803			\$ 2,570,408	\$ * 1,297,605	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: 1/1/07 Ending: 12/13/07

## 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: 1/1/07

Ending: 12/13/07

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						436,716	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				\$	\$		\$ 1,182,248	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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1										1										
2										2										
3										3										
4										4										
5										5										
<b>Working Capital</b>																				
6	Peoria County, Illinois	X		Operations	none	n/a		538,451	none	variable	101,538	6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>						\$	538,451			\$	101,538	9							
<b>B. Non-Facility Related*</b>																				
10												10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$				\$		14							
15	<b>TOTALS (line 9+line14)</b>						\$	538,451			\$	101,538	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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

**2006 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 2006 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 2006.

(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. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ _____	\$ _____

**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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

**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:

1/1/07 Ending:

12/13/07

**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).

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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>	1
2					2
3	<b>TOTALS</b>	<b>#VALUE!</b>		<b>\$ 100</b>	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Bel-Wood Nursing Home

# 0004499

Report Period Beginning:

1/1/07

Ending:

12/13/07

**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	\$ 62,471	50	\$ 62,471		\$ 2,436,153	4
5			1975	1975	4,223	92	45	92		3,097	5
6			1986	1986	47,151		various			47,151	6
7											7
8											8
	<b>Improvement Type**</b>										
9	Improvements		1978	1978	10,851	271	40	271		8,156	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		20			48,090	14
15	Improvements		1987	1987	4,741		various			4,741	15
16	Improvements		1988	1988	104,423	4,726	various	4,726		101,961	16
17	Improvements		1989	1989	160,076	7,778	various	7,778		152,591	17
18	Improvements		1990	1990	140,837		various			140,837	18
19	Improvements		1991	1991	1,057,735	51,643	various	51,643		864,971	19
20	Improvements		1992	1992	191,871	10,229	various	10,229		162,701	20
21	Improvements		1995	1995	4,885	244	16-20	244		2,987	21
22	Building Improvements		1995	1995	23,643	1,623	5-20	1,623		18,957	22
23	Resurface Driveway		1996	1996	2,947	184	16	184		1,932	23
24	Draperies		1996	1996	1,218		10			1,218	24
25	Telephone Wiring		1996	1996	2,383	119	20	119		1,230	25
26	Draperies		1996	1996	2,691	180	10	180		2,691	26
27	Faucets		1997	1997	1,862	93	20	93		938	27
28	Replace Floor		1997	1997	1,035	52	20	52		524	28
29	Remodeling		1997	1997	1,291	65	20	65		682	29
30	Door Replacement		1997	1997	4,957	248	20	248		2,687	30
31	Ceiling tile		1997	1997	1,488	99	15	99		1,064	31
32	Concrete Slabs		1997	1997	825	41	20	41		434	32
33	Sinks		1997	1997	3,718	186	20	186		1,937	33
34	Plumbing		1997	1997	2,397	96	25	96		1,000	34
35	Lights		1997	1997	9,479	527	18	527		4,125	35
36	Compressor		1997	1997	5,680	379	15	379		3,916	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 &amp; ID Number Bel-Wood Nursing Home

# 0004499

Report Period Beginning:

1/1/07

Ending:

12/13/07

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Fireplace	1998	\$ 946	\$ 47	20	\$ 47	\$	\$ 447	37
38	Bi-fold Doors	1998	27,343	2,734	10	2,734		24,606	38
39	Sink System	1998	2,569	128	20	128		1,238	39
40	Handrails	1998	1,955	196	10	196		1,862	40
41	Water Softener	1998	34,106	2,842	12	2,842		26,525	41
42	Roof Repair	1998	3,760	376	10	376		3,603	42
43	Draperies	1998	874	58	15	58		532	43
44	Covebase	1998	353	24	15	24		228	44
45	Wallpaper	1998	985	49	20	49		470	45
46	Wallpaper	1998	1,885	94	20	94		909	46
47	Wallpaper	1998	1,075	54	20	54		526	47
48	Wallpaper	1998	434	22	20	22		205	48
49	Roof Repairs	1998	3,467	347	10	347		3,123	49
50	Draperies	1998	1,872	125	15	125		1,125	50
51	Underground Storage Tank	1998	26,041	651	40	651		6,510	51
52	Energy management system modifications	1999	3,732	373	10	373		3,233	52
53	Curtains	1999	797	80	10	80		686	53
54	Roof Repairs	1999	1,254	84	15	84		714	54
55	Architect fees per IDPA review of 1999 cost report	1999	15,290	1,911	8	1,911		9,555	55
56	Shelving, dish room	2000	1,500	75	20	75		581	56
57	Door relocation	2000	1,461	73	20	73		560	57
58	Roof Repairs	2000	3,552	237	15	237		1,797	58
59	Water Main #1	2000	3,178	127	25	127		953	59
60	Sidewalk Replacement	2000	1,350	68	20	68		510	60
61	Draperies	2000	4,839	484	10	484		3,590	61
62	Water Main #2	2000	2,120	85	25	85		623	62
63	Draperies	2000	728	73	10	73		529	63
64	Door guards	2000	1,694	85	20	85		616	64
65	Door, magnetic lock	2000	4,062	203	20	203		1,455	65
66	Replacement glass	2001	2,971	149	20	149		1,030	66
67	Fire System	2001	496	62	8	62		424	67
68	Water heater replacement	2001	84,666	10,583	8	10,583		71,189	68
69	Drawer front machine	2001	1,690	113	15	113		763	69
70	TOTAL (lines 4 thru 69)		\$ 5,875,498	\$ 163,958		\$ 163,958	\$	\$ 4,856,171	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Bel-Wood Nursing Home

# 0004499

Report Period Beginning:

1/1/07

Ending:

12/13/07

**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	<b>Totals from Page 12A, Carried Forward</b>		\$ 5,875,498	\$ 163,958		\$ 163,958	\$	\$ 4,856,171	1
2	Windows	2002	59,439	2,972	20	2,972		15,603	2
3	Resident Alarm System	2002	43,538	2,177	20	2,177		11,066	3
4	Exit Device	2002	1,862	186	10	186		930	4
5	Egress Bars for doors	2002	2,630	263	10	263		1,337	5
6	Rooftop Unit Pilot Program Phse 1	2002	1,420	95	15	95		475	6
7	Construction Documents	2002	6,750	844	8	844		4,220	7
8	Control Wiring	2002	2,495	125	20	125		698	8
9	Roof Repairs	2002	1,642	109	15	109		627	9
10	Exit Signs	2003	2,596	260	10	260		1,278	10
11	Air Cylinder - Drain	2003	1,049	105	10	105		490	11
12	Zone Motor & Bases	2003	4,211	421	10	421		1,824	12
13	Construction Documentation	2003	12,854	1,607	8	1,607		6,830	13
14	Fence for Alzheimer Unit	2003	4,277	285	15	285		1,211	14
15	Parking lot overlay	2003	39,414	2,463	16	2,463		10,468	15
16	Water heater replacement	2003	52,500	3,500	15	3,500		14,875	16
17	Engineering	2003	3,700	463	8	463		1,929	17
18	Water main replacement	2003	80,810	3,232	25	3,232		13,197	18
19	Fire alarm panel replacement	2003	22,710	1,136	20	1,136		4,639	19
20	Reception Area Remodel	2003	2,904	145	20	145		580	20
21	Double Egress Doors	2004	2,585	259	10	259		906	21
22	Alzheimer Security	2004	26,381	5,276	5	5,276		18,026	22
23	Wallpaper HC & Norwood	2004	3,237	647	5	647		2,211	23
24	Blinds HC & Glasford	2004	6,070	1,214	5	1,214		4,148	24
25	Fire Alarm system	2004	111,652	11,165	10	11,165		37,217	25
26	Aluminum Awning	2004	1,726	173	10	173		562	26
27	Roof Repairs	2004	3,383	338	10	338		1,042	27
28	Fire alarm wiring	2004	5,812	581	10	581		1,743	28
29	Electrical service	2004	3,132	313	10	313		965	29
30	Compressor repairs	2004	10,589	2,118	5	2,118		6,354	30
31	Reception area shades	2004	2,062	412	5	412		1,614	31
32	Addition to watermain	2004	30,505	1,271	24	1,271		4,766	32
33	Door closer and locks	2004	2,366	237	10	237		888	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,431,799	\$ 208,350		\$ 208,350	\$	\$ 5,028,890	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Bel-Wood Nursing Home

# 0004499

Report Period Beginning:

1/1/07

Ending:

12/13/07

**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	<b>Totals from Page 12B, Carried Forward</b>		\$ 6,431,799	\$ 208,350		\$ 208,350	\$	\$ 5,028,890	1
2	Water heater replacement	2005	1,204	240	5	240		580	2
3	Roof Repairs - Massey	2005	15,793	1,579	10	1,579		3,290	3
4	Engine Control Panel	2005	35,025	1,751	20	1,751		4,670	4
5	Door closers and locks	2005	899	90	10	90		187	5
6	Carpeting	2005	1,735	347	5	347		954	6
7	Sink Repairs	2005	5,514	1,103	5	1,103		2,574	7
8	AA D379 Engine Repair	2005	1,300	260	5	260		780	8
9	Front Door Repair	2005	1,235	247	5	247		659	9
10	Carpeting	2005	1,563	313	5	313		756	10
11	C-wing Faux Wood Blinds	2005	4,998	1,000	5	1,000		2,500	11
12	Water Softener Overhaul	2005	1,574	315	5	315		787	12
13	Smoke Detector	2005	1,710	171	10	171		499	13
14	4 Plexiglass Flower Boxes	2005	1,580	316	5	316		922	14
15	Domestic Hot Water Temp Valve	2005	2,082	416	5	416		1,214	15
16	Carpeting	2005	7,333	1,467	5	1,467		3,912	16
17	HVAC Repairs	2005	103,550	20,710	5	20,710		51,775	17
18	Booster Pump	2006	4,000	800	5	800		867	18
19	Doors and Locks	2006	8,760	1,752	5	1,752		1,898	19
20	Door Latch Replacement	2006	28,360	5,672	5	5,672		10,399	20
21	Roof Repairs	2006	19,515	3,252	3	3,252		6,504	21
22	HVAC Repairs	2006	52,475	8,746	3	8,746		17,492	22
23	Victory chiller swing door	2007	9,573		10				23
24	HVAC repairs	2007	44,128		3				24
25	Roof repairs	2007	9,240		3				25
26	Electrical upgrade	2007	42,840		10				26
27	Boiler pump	2007	3,274		5				27
28	Smoke dampers	2007	31,696		10				28
29	Fire Alarm	2007	6,770	506	10	506		506	29
30	Water back flows	2007	3,977	597	5	597		597	30
31	Outdoor walk-in freezer	2007	22,300	1,673	10	1,673		1,673	31
32	Carpeting	2007	3,172	423	5	423		423	32
33	Draper shades for hallway	2007	9,820	982	5	982		982	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,918,794	\$ 263,078		\$ 263,078	\$	\$ 5,146,290	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:

1/1/07

Ending:

12/13/07

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	
1	Totals from Page 12C, Carried Forward		\$ 6,918,794	\$ 263,078		\$ 263,078	\$	\$ 5,146,290	1
2	Disposal	2007	3,749	312	5	312		312	2
3	Front door patient alarm	2007	2,580	215	5	215		215	3
4	Firewall for IDPH	2007	3,450	173	5	173		173	4
5	Booster pump	2007	47,390	1,580	5	1,580		1,580	5
6	Ceiling tile replacement	2007	15,493	516	5	516		516	6
7	Sidewalks	2007	4,060	203	10	203		203	7
8									8
9									9
10									10
11									11
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,995,516	\$ 266,077		\$ 266,077	\$	\$ 5,149,289	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: 1/1/07 Ending: 12/13/07

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	\$ 804,825	\$ 102,254	\$ 102,254	\$	5-20	\$ 494,116	71
72	Current Year Purchases	63,614	1,677	1,677		3-10	1,677	72
73	Fully Depreciated Assets	236,283	2,049	2,049		5-20	236,283	73
74								74
75	TOTALS	\$ 1,104,722	\$ 105,980	\$ 105,980	\$		\$ 732,076	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	\$ 1,750	\$ 1,750	\$	8	\$ 13,269	76
77	Resident	1997 Ford El Dorado	1997	42,701				4	42,701	77
78										78
79										79
80	TOTALS			\$ 56,699	\$ 1,750	\$ 1,750	\$		\$ 55,970	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)	\$ 8,157,037	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 373,807	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 373,807	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)	\$ 5,937,335	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	<b>TOTAL</b>				\$ _____			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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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	<b>TOTAL</b>		\$ _____	\$ _____	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: 1/1/07 Ending: 12/13/07

**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>
--	--	---

Bel-Wood has incurred a Civil Money Penalty and is prohibited from offering CNA training under a 2005 settlement agreement with CMS.

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	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)	
<b>TOTAL TRAINED</b>	

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

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

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

Report Period Beginning:

1/1/07

Ending:

12/13/07

## 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	<b>TOTAL</b>			\$		\$	\$		\$	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 # 0004499 Report Period Beginning: 1/1/07 Ending: 12/13/07

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/13/07 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 30,614	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 350,000 )	3,422,690		3
4	Supply Inventory (priced at cost )	62,387		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	21,596		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 3,537,287	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	100		13
14	Buildings, at Historical Cost	6,760,339		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,161,421		16
17	Accumulated Depreciation (book methods)	(5,682,561)		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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 2,239,299	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 5,776,586	\$	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 897,576	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	670,798		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Due to other funds</u>	538,451		36
37	<u>Deferred revenue</u>	217,613		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,324,438	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,324,438	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 3,452,148	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 5,776,586	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 786,822	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 786,822	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	2,732,913	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>	(59,903)	15
16	Other (describe) <u>dif in method used for depreciation</u>	(21,107)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 2,651,903	17
<b>B. Transfers (Itemize):</b>			
18	<u>Transfers in from other County Funds</u>	13,423	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 13,423	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,452,148	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bel-Wood Nursing Home# 0004499Report Period Beginning: 1/1/07Ending: 12/13/07**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 17,517,204	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 17,517,204	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	961,133	6
7	Oxygen	82,789	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,043,922	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants	1,659,262	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	4,722	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	281,497	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 1,949,675	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	24,273	24
25	Interest and Other Investment Income***	30,067	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 54,340	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Vending Income</b>	9,591	28
28a	<b>Miscellaneous</b>	1,901	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 11,492	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 20,576,633	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	2,642,356	31
32	Health Care	8,635,852	32
33	General Administration	5,917,926	33
<b>B. Capital Expense</b>			
34	Ownership	483,336	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	164,250	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 17,843,720	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	2,732,913	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 2,732,913	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:

1/1/07

Ending:

12/13/07

**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	1,510	1,758	\$ 68,259	\$ 38.83	1
2	Assistant Director of Nursing	2,638	2,965	85,648	28.89	2
3	Registered Nurses	11,946	13,267	331,627	25.00	3
4	Licensed Practical Nurses	47,178	53,167	1,076,720	20.25	4
5	CNAs & Orderlies	244,031	271,479	3,832,588	14.12	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,592	1,956	67,138	34.32	9
10	Activity Assistants	9,714	11,487	233,574	20.33	10
11	Social Service Workers	3,471	4,198	89,054	21.21	11
12	Dietician					12
13	Food Service Supervisor	1,740	2,101	56,797	27.03	13
14	Head Cook	1,944	2,197	46,258	21.06	14
15	Cook Helpers/Assistants	44,625	50,795	614,409	12.10	15
16	Dishwashers					16
17	Maintenance Workers	5,318	5,794	92,189	15.91	17
18	Housekeepers	36,361	41,667	520,279	12.49	18
19	Laundry	9,607	11,135	135,986	12.21	19
20	Administrator	1,299	1,379	75,280	54.59	20
21	Assistant Administrator					21
22	Other Administrative	8,038	9,099	136,025	14.95	22
23	Office Manager					23
24	Clerical	5,858	6,405	79,257	12.37	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	3,937	4,489	79,226	17.65	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	440,807	495,338	\$ 7,620,314 *	\$ 15.38	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	1,720	L10-C3	37
38	Nurse Consultant			38
39	Pharmacist Consultant			39
40	Physical Therapy Consultant	257,837	L10a-C3	40
41	Occupational Therapy Consultant	284,833	L10a-C3	41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant	131,697	L10a-C3	43
44	Activity Consultant	497	L11-C3	44
45	Social Service Consultant	541	L12-C3	45
46	Other(specify) <u>Management Consultant</u>	66,579	L17-C3	46
47	<u>Architectural Consultant</u>	24,838	L17-C3	47
48				48
49	TOTAL (lines 35 - 48)	\$ 773,542		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	3,256	\$ 136,201	L10-C3	50
51	Licensed Practical Nurses	29,774	917,653	L10-C3	51
52	Certified Nurse Assistants/Aides	7,788	131,526	L10-C3	52
53	TOTAL (lines 50 - 52)	40,817	\$ 1,185,380		53

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number Bel-Wood Nursing Home

Report Period Beginning: 1/1/07 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 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; 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? 7.0
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 173,014 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. \$ 4,722
- (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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT