



Facility Name & ID Number Bel-Wood Nursing Home

# 0004499 Report Period Beginning: 01/01/09 Ending: 12/31/09

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	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 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	10,908	1,638	6,060	18,606	8
9	SNF/PED					9
10	ICF	58,309	17,031		75,340	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	69,217	18,669	6,060	93,946	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.80%

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  Note: Non-allowable costs have been eliminated in Schedule V, Column 7.

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 6,060

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/2009

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

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**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	729,968	45,377		775,345		775,345		775,345		1
2	Food Purchase		491,399		491,399		491,399	(4,478)	486,921		2
3	Housekeeping	514,545	49,726	19,247	583,518		583,518		583,518		3
4	Laundry	153,975	36,926		190,901		190,901	(4,194)	186,707		4
5	Heat and Other Utilities			385,109	385,109		385,109		385,109		5
6	Maintenance	103,640	33,377	80,566	217,583		217,583	6,299	223,882		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	1,502,128	656,805	484,922	2,643,855		2,643,855	(2,373)	2,641,482		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			5,000	5,000		5,000		5,000		9
10	Nursing and Medical Records	5,726,521	567,752	818,250	7,112,523		7,112,523		7,112,523		10
10a	Therapy		1,767	757,949	759,716		759,716		759,716		10a
11	Activities	385,366	6,951	496	392,813		392,813		392,813		11
12	Social Services	198,567		248	198,815		198,815		198,815		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	6,310,454	576,470	1,581,943	8,468,867		8,468,867		8,468,867		16
	<b>C. General Administration</b>										
17	Administrative	111,611		186,000	297,611		297,611	6,070	303,681		17
18	Directors Fees							61,559	61,559		18
19	Professional Services			161,506	161,506		161,506	119,311	280,817		19
20	Dues, Fees, Subscriptions & Promotions			20,692	20,692		20,692		20,692		20
21	Clerical & General Office Expenses	220,398	6,430	53,439	280,267		280,267	121,212	401,479		21
22	Employee Benefits & Payroll Taxes			783,172	783,172		783,172	651,001	1,434,173		22
23	Inservice Training & Education			6,208	6,208		6,208		6,208		23
24	Travel and Seminar			14,344	14,344		14,344		14,344		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			223,803	223,803		223,803	(113,392)	110,411		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	332,009	6,430	1,449,164	1,787,603		1,787,603	845,761	2,633,364		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	8,144,591	1,239,705	3,516,029	12,900,325		12,900,325	843,388	13,743,713		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.

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## 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			423,758	423,758		423,758	(26,899)	396,859			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			53,564	53,564		53,564		53,564			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			477,322	477,322		477,322	(26,899)	450,423			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		167,619	49,555	217,174		217,174	(49,555)	167,619			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			3,055,538	3,055,538		3,055,538		3,055,538			42
43	Other (specify):* <b>Non-allowable cost</b>			73,794	73,794		73,794	(73,794)				43
44	<b>TOTAL Special Cost Centers</b>		167,619	3,178,887	3,346,506		3,346,506	(123,349)	3,223,157			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	8,144,591	1,407,324	7,172,238	16,724,153		16,724,153	693,140	17,417,293			45

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

\*\* See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(26,899)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(10,010)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(29,723)	43		24
25	Fund Raising, Advertising and Promotional	(33,407)	43		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 See PG5A	(74,157)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (174,196)		\$	30

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

		1	2	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	867,336	various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 867,336		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 693,140		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

**C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)**

		1	2	3	4
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
38	Medically Necessary Transport.		x	\$	38
39					39
40	Gift and Coffee Shops		x		40
41	Barber and Beauty Shops		x		41
42	Laboratory and Radiology		x		42
43	Prescription Drugs		x		43
44					44
45	Other-Attach Schedule		x		45
46	Other-Attach Schedule		x		46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

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

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2	Offset meal revenue	(4,478)	2	2
3	Offset non-resident laundry revenue	(4,194)	4	3
4	Loss on disposition of assets	(6,575)	43	4
5	Disallow Medicare Ancillary Costs	(49,555)	39	5
6	Employee Recognitions & Awards	(1,714)	22	6
7	Accrued Compensated Absence Audit Expense	5,921	43	7
8	Disallow Cable TV	(13,562)	21	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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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>	(74,157)		49

**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	N/A		N/A		

**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: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
1	V	6 Facility Management	\$	Peoria County	100.00%	\$ 6,299	\$	6,299	1
2	V	17 Management Fee	186,000	Peoria County	100.00%	192,070		6,070	2
3	V	18 County Board		Peoria County	100.00%	61,559		61,559	3
4	V	19 Proffessional Services	144,773	Peoria County	100.00%	264,084		119,311	4
5	V	21 Clerical Services		Peoria County	100.00%	134,774		134,774	5
6	V	22 Employee Benefits-Health	724,212	Peoria County	100.00%	432,413		(291,799)	6
7	V	22 IMRF		Peoria County	100.00%	241,477		241,477	7
8	V	22 FICA		Peoria County	100.00%	534,632		534,632	8
9	V	22 EmployeeBenefits-WorkComp	194,282	Peoria County	100.00%	117,744		(76,538)	9
10	V	22 Employee Benefits - U/C	10,250	Peoria County	100.00%	50,661		40,411	10
11	V	26 Liability Insurance	19,271	Peoria County	100.00%	110,411		91,140	11
12	V								12
13	V								13
14	Total		\$ 1,278,788			\$ 2,146,124	\$ *	867,336	14

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

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## 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	2	3	4	5	6		7		8	9	
					Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**				
Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference		
1		Operating Board						\$		1	
2	Lynn Scott Pearson	Chairperson	Administrative	0.00	N/A	2	0.05	N/A	N/A	N/A	2
3	Bonnie J. Hester	Vice-Chairperson	Administrative	0.00	N/A	1	0.03	N/A	N/A	N/A	3
4	Brian Elsasser	Member	Administrative	0.00	N/A	1	0.03	N/A	N/A	N/A	4
5	Patricia Hidden	Member	Administrative	0.00	N/A	1	0.03	N/A	N/A	N/A	5
6	Phillip Salzer	Member	Administrative	0.00	N/A	1	0.03	N/A	N/A	N/A	6
7	Merle Widmer	Member	Administrative	0.00	N/A	1	0.03	N/A	N/A	N/A	7
8											8
9											9
10											10
11	Andrew Rand, a member of the Peoria County Board, is CEO of Advanced Medical Transport of Central Illinois which furnished medical transportation for Bel-Wood.									11	
12	Mr. Rand is not a member of the Health & Environmental Svcs. Committee which directly oversees Bel-Wood Nursing Home.									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

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VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization Peoria County  
 Street Address Room 501 , Peoria County Courthouse  
 City / State / Zip Code Peoria, IL 61602  
 Phone Number ( 309-672-6056  
 Fax Number ( 309-672-6065

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

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

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	Facility Management	Direct allocation per		\$	\$		\$ 6,299	1
2	18	County Board	Maximus, Inc. Please					61,559	2
3	19	Professional Services	see attached schedule.					264,084	3
4	21	Clerical Services	Further detail					134,774	4
5	22	Employee Benefits-Health	available upon					432,413	5
6	22	Employee Benefits-Work Comp	request.					110,411	6
7	22	Employee Benefits-U/C						117,744	7
8	26	Liability Insurance						50,661	8
9									9
10	17	Management Fee	Direct Cost					192,070	10
11	22	IMRF	Direct Cost					241,477	11
12	22	FICA	Direct Cost					435,632	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				\$	\$		\$ 2,047,124	25

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**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
<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						N/A				6									
7										7									
8										8									
9	<b>TOTAL Facility Related</b>					\$	\$		\$	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>					\$	\$		\$	15									

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

\* 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.)





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**X. BUILDING AND GENERAL INFORMATION:**

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

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).

None

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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Resident Care</u>	<u>348,480</u>	<u>1848</u>	<u>\$ 100</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>348,480</b>		<b>\$ 100</b>	<b>3</b>

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**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	\$	\$ 2,498,624	4
5		1975	1975	4,223	92	45	92		3,189	5
6		1986	1986	47,151		Various			47,151	6
7										7
8										8
	<b>Improvement Type**</b>									
9	Improvements		1978	10,851	271	40	271		8,427	9
10	Improvements		1979	23,127		20-25			23,127	10
11	Improvements		1980	115,619		20-25			115,619	11
12	Improvements		1984	15,544		Various			15,544	12
13	Improvements		1985	511,366		Various			511,366	13
14	Improvements		1986	45,660		20			45,660	14
15	Improvements		1987	936		Various			936	15
16	Improvements		1988	104,423		Various			104,423	16
17	Improvements		1989	158,141		Various			158,141	17
18	Improvements		1990	140,837		Various			140,837	18
19	Improvements		1991	599,124	29,956	Various	29,956		472,811	19
20	Improvements		1992	188,119	9,901	Various	9,901		179,658	20
21	Improvements		1995	4,885	244	16-20	244		3,475	21
22	Building Improvements (2009 - disposal of 8774)		1995	14,869	1,418	5-20	1,418		14,869	22
23	Resurface Driveway		1996	2,947	184	16	184		2,300	23
24	Telephone Wiring		1996	2,383	119	20	119		1,468	24
25	Faucets		1997	1,862	93	20	93		1,124	25
26	Replace Floor		1997	1,035	52	20	52		628	26
27	Remodeling		1997	1,291	65	20	65		812	27
28	Door Replacement		1997	4,957	248	20	248		3,183	28
29	Ceiling tile		1997	1,488	99	15	99		1,262	29
30	Concrete Slabs		1997	825	41	20	41		516	30
31	Sinks		1997	3,718	186	20	186		2,309	31
32	Plumbing		1997	2,397	96	25	96		1,192	32
33	Compressor (disposed of in 2009)		1997							33
34	Fireplace		1998	946	47	20	47		541	34
35	Bi-fold Doors		1998	27,343	3	10	3		27,343	35
36	Sink System		1998	2,569	128	20	128		1,494	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:

01/01/09

Ending:

12/31/09**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	<u>Handrails</u>	1998	\$ 1,955	\$	10	\$	\$	\$ 1,955	37
38	<u>Water Softener</u>	1998	34,106	2,842	12	2,842		32,209	38
39	<u>Roof Repair</u>	1998	3,760		10			3,760	39
40	<u>Wallpaper</u>	1998	985	49	20	49		568	40
41	<u>Wallpaper</u>	1998	1,885	94	20	94		1,097	41
42	<u>Wallpaper</u>	1998	1,075	54	20	54		634	42
43	<u>Wallpaper</u>	1998	434	22	20	22		249	43
44	<u>Roof Repair</u>	1998	3,467		10			3,467	44
45	<u>Underground Storage Tank</u>	1998	26,041	651	40	651		7,812	45
46	<u>Energy Management System Modifications</u>	1999	3,732	126	10	126		3,732	46
47	<u>Roof Repairs</u>	2000	1,254	84	15	84		882	47
48	<u>Architect fees per IDPA review of 1999 cost report</u>	2000	15,290	1,911	8	1,911		13,377	48
49	<u>Shelving, dish room</u>	2000	1,500	75	20	75		731	49
50	<u>Door relocation</u>	2000	1,461	73	20	73		706	50
51	<u>Roof Repairs</u>	2000	3,552	237	15	237		2,271	51
52	<u>Water Main #1</u>	2000	3,178	127	25	127		1,207	52
53	<u>Sidewalk Replacement</u>	2000	1,350	68	20	68		646	53
54	<u>Water Main #2</u>	2000	2,120	85	25	85		793	54
55	<u>Door guards</u>	2000	1,694	85	20	85		786	55
56	<u>Door, magnetic lock</u>	2000	4,062	203	20	203		1,861	56
57	<u>Replacement glass</u>	2001	2,971	149	20	149		1,328	57
58	<u>Fire System</u>	2001	496	10	8	10		496	58
59	<u>Water heater replacement</u>	2001	84,666	2,894	8	2,894		84,666	59
60	<u>Drawer front machine</u>	2001	1,690	113	15	113		989	60
61	<u>Windows</u>	2002	59,439	2,972	20	2,972		21,547	61
62	<u>Resident Alarm System</u>	2002	43,538	2,177	20	2,177		15,420	62
63	<u>Exit Device</u>	2002	1,862	186	10	186		1,392	63
64	<u>Egress Bars for Doors</u>	2002	2,630	263	10	263		1,863	64
65	<u>Rooftop Unit Pilot Program Phase 1</u>	2002	1,420	95	15	95		665	65
66	<u>Construction Documents</u>	2002	6,750	844	8	844		5,908	66
67	<u>Control Wiring</u>	2002	2,495	125	20	125		948	67
68	<u>Roof Repairs</u>	2002	1,642	109	15	109		845	68
69	<u>Exit Signs</u>	2003	2,596	260	10	260		1,798	69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 5,487,005	\$ 122,696		\$ 122,696	\$	\$ 4,604,637	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:

01/01/09

Ending:

12/31/09**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 5,487,005	\$ 122,696		\$ 122,696	\$	\$ 4,604,637	1
2	<u>Air Cylinder - Drain</u>	2003	1,049	105	10	105		700	2
3	<u>Zone Motor &amp; Bases</u>	2003	4,211	421	10	421		2,666	3
4	<u>Construction Documentation</u>	2003	12,854	1,607	8	1,607		10,044	4
5	<u>Fence for Alzheimer Unit</u>	2003	4,277	285	15	285		1,781	5
6	<u>Parking lot overlay</u>	2003	39,414	2,463	16	2,463		15,394	6
7	<u>Water heater replacement</u>	2003	52,500	3,500	15	3,500		21,875	7
8	<u>Engineering</u>	2003	3,700	463	8	463		2,855	8
9	<u>Water main replacement</u>	2003	80,810	3,232	25	3,232		19,661	9
10	<u>Fire alarm panel replacement</u>	2003	22,710	1,136	20	1,136		6,911	10
11	<u>Reception Area Remodel</u>	2003	2,904	145	20	145		870	11
12	<u>Double Egress Doors</u>	2004	2,585	259	10	259		1,424	12
13	<u>Alzheimer Security</u>	2004	26,381	5,276	5	5,276		28,578	13
14	<u>Wallpaper HC &amp; Norwood</u>	2004	3,237	647	5	647		3,505	14
15	<u>Blinds HC &amp; Glasford</u>	2004	6,070	1,214	5	1,214		6,576	15
16	<u>Fire Alarm system</u>	2004	111,652	11,165	10	11,165		59,547	16
17	<u>Aluminum Awning (disposed of in 2009)</u>	2004			10				17
18	<u>Roof Repairs</u>	2004	3,383	338	10	338		1,718	18
19	<u>Fire alarm wiring</u>	2004	5,812	581	10	581		2,905	19
20	<u>Electrical service</u>	2004	3,132	313	10	313		1,591	20
21	<u>Compressor repairs</u>	2004	10,589	2,118	5	2,118		10,590	21
22	<u>Reception area shades</u>	2004	2,062		5			2,062	22
23	<u>Addition to watermain</u>	2004	30,505	1,271	24	1,271		7,308	23
24	<u>Door closer and locks</u>	2004	2,366	237	10	237		1,362	24
25	<u>Water heater replacement</u>	2005	1,204	240	5	240		1,060	25
26	<u>Roof Repairs - Massey</u>	2005	15,793	1,579	10	1,579		6,448	26
27	<u>Engine Control Panel</u>	2005	35,025	1,751	20	1,751		8,172	27
28	<u>Door closer and locks</u>	2005	899	90	10	90		367	28
29	<u>Carpeting</u>	2005	1,735	347	5	347		1,648	29
30	<u>Sink Repairs</u>	2005	5,514	1,103	5	1,103		4,780	30
31	<u>AA D379 Engine Repair</u>	2005	1,300	260	5	260		1,300	31
32	<u>Front Door Repair</u>	2005	1,235	247	5	247		1,153	32
33	<u>Carpeting</u>	2005	1,563	313	5	313		1,382	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 5,983,476	\$ 165,402		\$ 165,402	\$	\$ 4,840,870	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:

01/01/09

Ending:

12/31/09**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 5,983,476	\$ 165,402		\$ 165,402	\$	\$ 4,840,870	1
2	C-wing Faux Wood Blinds	2005	4,998	1,000	5	1,000		4,500	2
3	Water Softener Overhaul	2005	1,574	315	5	315		1,417	3
4	Smoke Detector	2005	1,710	171	10	171		841	4
5	4 Plexiglass Flower Boxes	2005	1,580	316	5	316		1,554	5
6	Domestic Hot Water Temp Valve	2005	2,082	416	5	416		2,046	6
7	Carpeting	2005	7,333	1,467	5	1,467		6,846	7
8	HVAC Repairs	2005	103,550	20,710	5	20,710		93,195	8
9	Booster Pump	2006	4,000	800	5	800		2,467	9
10	Doors and Locks	2006	8,760	1,752	5	1,752		5,402	10
11	Door Latch Replacement	2006	28,360	5,672	5	5,672		21,743	11
12	Roof Repairs	2006	19,515	6,506	3	6,506		19,515	12
13	HVAC Repairs	2006	52,475	17,492	3	17,492		52,475	13
14	Victory chiller swing door	2007	9,573	957	10	957		1,914	14
15	HVAC repairs	2007	44,128	14,709	3	14,709		29,418	15
16	Roof repairs	2007	9,240	3,080	3	3,080		6,160	16
17	Electrical upgrade	2007	42,840	4,284	10	4,284		8,568	17
18	Boiler pump	2007	3,274	655	5	655		1,310	18
19	Smoke dampers	2007	31,696	3,170	10	3,170		6,340	19
20	Fire Alarm	2007	6,770	677	10	677		1,860	20
21	Water back flows	2007	3,977	795	5	795		2,187	21
22	Outdoor walk-in freezer	2007	22,300	2,230	10	2,230		3,903	22
23	Carpeting	2007	3,172	634	5	634		1,691	23
24	Draper shades for hallway	2007	9,820	1,964	5	1,964		4,910	24
25	Disposal (disposed of in 2009)	2007							25
26	Front Door Patient Alarm	2007	2,580	516	5	516		1,247	26
27	Firewall for IDPH	2007	3,450	690	5	690		1,553	27
28	Booster Pump	2007	47,390	9,478	5	9,478		20,536	28
29	Ceiling Tile Replacement	2007	15,493	3,099	5	3,099		6,714	29
30	Sidewalks	2007	4,060	406	10	406		1,015	30
31	Main Entrance Delayed Exit A	2008	3,415	1,138	3	1,138		1,517	31
32	HVAC Repairs	2008	64,942	21,647	3	21,647		21,647	32
33	Roof Repairs	2008	8,308	2,769	3	2,769		2,769	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,555,841	\$ 294,918		\$ 294,917	\$	\$ 5,178,130	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

**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	<b>Totals from Page 12C, Carried Forward</b>		\$ 6,555,841	\$ 294,918		\$ 294,917	\$	\$ 5,178,130	1
2	Boiler Replacement	2008	18,200	6,067	3	6,067	0	11,123	2
3	Hot Water Heater Repairs	2008	3,606	1,202	3	1,202		1,703	3
4	Faux Wood Blinds	2008	22,596	7,532	3	7,532		7,532	4
5									5
6	HVAC Repairs	2009	76,683		2				6
7	Roof Repairs	2009	14,328		2				7
8	Flooring - First Floor	2009	4,657	970	2	970		970	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	Adjust to financial statement information			23,807			(23,807)	74,863	31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,695,911	\$ 334,496		\$ 310,688	\$ (23,807)	\$ 5,274,321	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 608,928	\$ 77,417	\$ 74,325	\$ (3,092)		\$ 461,040	71
72	Current Year Purchases	80,651	2,613	2,613			2,613	72
73	Fully Depreciated Assets	349,414	9,232	9,232			349,414	73
74								74
75	TOTALS	\$ 1,038,993	\$ 89,262	\$ 86,170	\$ (3,092)		\$ 813,067	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	Facility Maintenance	2010 Dodge Ram Truck	2000	\$ 13,998	\$	\$	\$	8	\$ 13,998	76
77	Resident Transportation	1997 Ford El Dorado	1997	42,701				4	42,701	77
78										78
79										79
80	TOTALS			\$ 56,699	\$	\$	\$		\$ 56,699	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)	\$ 7,791,703	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 423,758	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 396,859	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (26,899)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,144,087	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	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Progress	\$ 750,686	92
93			93
94			94
95		\$ 750,686	95

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.  YES  NO

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

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 53,564 Description: Medical Equipment - 50,778; Duplicating Equipment - 2,786

(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			<u>N/A</u>		18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2012 \$ \_\_\_\_\_

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
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**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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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**

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(2),(3)	hrs	\$	4,138	\$ 297,910	\$ 1,767	4,138	\$ 299,677	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,501	180,101		2,501	180,101	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		3,888	279,938		3,888	279,938	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				167,619		167,619	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): <u>Medicare Ancillaries</u>	39(3)				49,555			49,555	13
14	<b>TOTAL</b>			\$	10,527	\$ 807,504	\$ 169,386	10,527	\$ 976,890	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: **01/01/09**

Ending: **12/31/09**

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

As of **12/31/09**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 3,661,644	\$ 3,661,644	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>542,000</u> )	1,560,529	1,560,529	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments	3,000,000	3,000,000	5
6	Prepaid Insurance	131,013	131,013	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 8,353,186	\$ 8,353,186	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	100	100	13
14	Buildings, at Historical Cost	6,291,347	3,174,647	14
15	Leasehold Improvements, at Historical Cost	165,647	3,521,264	15
16	Equipment, at Historical Cost	1,095,692	1,095,692	16
17	Accumulated Depreciation (book methods)	(5,883,684)	(6,144,087)	17
18	Deferred Charges	4,560	4,560	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <u>Constr in process</u> )	750,686	750,686	22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 2,424,348	\$ 2,402,862	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 10,777,534	\$ 10,756,048	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 423,484	\$ 423,484	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	100,065	100,065	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>See Schedule 17A</u>	474,358	474,358	36
37	<u>Due to the State of Illinois</u>	1,447,220	1,447,220	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,445,127	\$ 2,445,127	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>	\$ 2,445,127	\$ 2,445,127	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 8,332,407	\$ 8,310,921	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 10,777,534	\$ 10,756,048	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

Bel-Wood Nursing Home  
Provider ID#: 0004499  
FYE 12/31/09

Supplementary Information

Schedule 17A

XV. BALANCE SHEET - Line 36 - Other Current Liabilities

	<u>Operating</u>	<u>After Consolidation</u>
Accrued Vacation & Comp Time	290,460	290,460
Deferred Revenue	183,300	183,300
Miscellaneous Due to Others	598	598
Total P17 L 36	<u>474,358</u>	<u>474,358</u>

See Accountants' Compliance Report

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>5,265,716</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>5,265,716</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>3,066,695</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>Rounding</b>	<b>(4)</b>	<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>3,066,691</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>8,332,407</b>	<b>24</b> *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bel-Wood Nursing Home# 0004499Report Period Beginning: 01/01/09Ending: 12/31/09

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 15,269,827	1
2	Discounts and Allowances for all Levels	1,057,114	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 16,326,941</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,165,502	6
7	Oxygen	62,006	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 1,227,508</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	195,212	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 195,212</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions	4,145	24
25	Interest and Other Investment Income***	20,642	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 24,787</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a	<u>See Schedule 19A</u>	2,016,400	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 2,016,400</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 19,790,848</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	2,643,855	31
32	Health Care	8,468,867	32
33	General Administration	1,787,603	33
<b>B. Capital Expense</b>			
34	Ownership	477,322	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	290,968	35
36	Provider Participation Fee	3,055,538	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 16,724,153</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>3,066,695</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 3,066,695</b>	<b>43</b>

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.  
Part of County. No return required

\*\*\* 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.

Bel-Wood Nursing Home  
Provider ID#: 0004499  
FYE 12/31/09

Supplementary Information

Schedule 19A

XVII. INCOME STATEMENT - Line 28a - Other Revenue

	<u>Amount</u>
Miscellaneous Fee for Services	9,495
Property Tax	1,838,312
Vending Machines	9,338
Recovery of Bad Debts	<u>159,255</u>
Total P19 L 28a	<u><u>2,016,400</u></u>

See Accountants' Compliance Report

Facility Name & ID Number **Bel-Wood Nursing Home**

# **0004499**

Report Period Beginning:

**01/01/09**

Ending:

**12/31/09**

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,760	2,056	\$ 86,065	\$ 41.86	1
2	Assistant Director of Nursing	1,769	2,072	59,572	28.75	2
3	Registered Nurses	13,735	16,545	411,783	24.89	3
4	Licensed Practical Nurses	63,347	77,921	1,502,326	19.28	4
5	CNAs & Orderlies	221,435	249,383	3,539,234	14.19	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,811	2,157	46,057	21.35	9
10	Activity Assistants	12,434	15,320	339,309	22.15	10
11	Social Service Workers	5,351	7,674	198,567	25.88	11
12	Dietician					12
13	Food Service Supervisor	2,596	3,186	76,621	24.05	13
14	Head Cook	1,811	2,943	48,414	16.45	14
15	Cook Helpers/Assistants	43,284	51,818	604,933	11.67	15
16	Dishwashers					16
17	Maintenance Workers	5,459	6,281	103,640	16.50	17
18	Housekeepers	30,617	41,364	514,545	12.44	18
19	Laundry	12,265	13,541	153,975	11.37	19
20	Administrator	1,861	2,512	111,611	44.43	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,583	15,601	220,398	14.13	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	3,585	4,239	75,712	17.86	31
32	Other Health Care: MDS/Care Plans	2,016	2,290	51,829	22.63	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	438,719	516,903	\$ 8,144,591 *	\$ 15.76	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	Monthly 5,000	9(3)	36	
37	Medical Records Consultant	Monthly 1,840	10(3)	37	
38	Nurse Consultant			38	
39	Pharmacist Consultant			39	
40	Physical Therapy Consultant			40	
41	Occupational Therapy Consultant			41	
42	Respiratory Therapy Consultant			42	
43	Speech Therapy Consultant			43	
44	Activity Consultant	Monthly 496	11(3)	44	
45	Social Service Consultant	Monthly 248	12(3)	45	
46	Other(specify)			46	
47	Management Consultant	40	5,794	21(3)	47
48				48	
49	TOTAL (lines 35 - 48)	40	\$ 13,378	49	

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	3,686	\$ 110,106	10(3)	50
51	Licensed Practical Nurses	20,926	629,711	10(3)	51
52	Certified Nurse Assistants/Aides	4,616	76,593	10(3)	52
53	TOTAL (lines 50 - 52)	29,228	\$ 816,410	53	

SEE ACCOUNTANTS' COMPILATION REPORT



Bel-Wood Nursing Home  
Provider ID#: 0004499  
FYE 12/31/09

Supplementary Information

Schedule 21A

XIXI. Support Schedules - Section C - Professional Services

	<u>Amount</u>
Per Schedule V, L19, C3	161,506
County Allocation	.
	119,311
	-
Per Schedule V, L19, C8	<u><u>280,817</u></u>

See Accountants' Compliance Report

**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	5-13 Amount of Expense Amortized Per Year								
					6 FY2006	7 FY2007	8 FY2008	9 FY2009	10 FY2010	11 FY2011	12 FY2012	13 FY2013	14 FY2014
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3								N/A					
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 & ID Number Bel-Wood Nursing Home# 0004499Report Period Beginning: 01/01/09Ending: 12/31/09**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. LSNI - 5,940; AAHSA - 4,168
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 186,782 Line 10(2)
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 3,055,538  
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? \_\_\_\_\_ 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. \$ 4,478
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? Yes  
If YES, attach a complete explanation. (See Page 21(G))
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 0
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- 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.** \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Clifton Gunderson LLP (Audits County)
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

**SEE ACCOUNTANTS' COMPILATION REPORT**