



Facility Name & ID Number Bel-Wood Nursing Home

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

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	109,800	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	109,800	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	4,500	585	5,390	10,475	8
9	SNF/PED					9
10	ICF	47,224	10,923	0	58,147	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	51,724	11,508	5,390	68,622	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.50%

D. How many bed-hold days during this year were paid by the Department?

None (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 5,390

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

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

Facility Name &amp; ID Number

Bel-Wood Nursing Home

# 0004499

Report Period Beginning:

01/01/12

Ending:

12/31/12

**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	661,074	36,344		697,418		697,418		697,418		1
2	Food Purchase		405,340		405,340		405,340	(16,497)	388,843		2
3	Housekeeping	394,085	56,608		450,693		450,693		450,693		3
4	Laundry	163,459	32,104		195,563		195,563		195,563		4
5	Heat and Other Utilities			350,859	350,859		350,859		350,859		5
6	Maintenance	119,751	29,437	110,881	260,069		260,069	6,213	266,282		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	1,338,369	559,833	461,740	2,359,942		2,359,942	(10,284)	2,349,658		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			5,002	5,002		5,002		5,002		9
10	Nursing and Medical Records	4,876,243	545,607	388,559	5,810,409		5,810,409	2,500	5,812,909		10
10a	Therapy										10a
11	Activities	288,268	7,013		295,281		295,281		295,281		11
12	Social Services	134,723		640	135,363		135,363		135,363		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	5,299,234	552,620	394,201	6,246,055		6,246,055	2,500	6,248,555		16
	<b>C. General Administration</b>										
17	Administrative	124,284		225,952	350,236		350,236	(225,952)	124,284		17
18	Directors Fees							98,041	98,041		18
19	Professional Services			168,530	168,530		168,530	176,489	345,019		19
20	Dues, Fees, Subscriptions & Promotions			20,331	20,331		20,331		20,331		20
21	Clerical & General Office Expenses	328,804	2,614	34,300	365,718		365,718	566,035	931,753		21
22	Employee Benefits & Payroll Taxes			652,364	652,364		652,364	1,212,923	1,865,287		22
23	Inservice Training & Education			2,074	2,074		2,074		2,074		23
24	Travel and Seminar			15,270	15,270		15,270	(5,149)	10,121		24
25	Other Admin. Staff Transportation			681	681		681		681		25
26	Insurance-Prop.Liab.Malpractice			228,276	228,276		228,276	(204,532)	23,744		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	453,088	2,614	1,347,778	1,803,480		1,803,480	1,617,855	3,421,335		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	7,090,691	1,115,067	2,203,719	10,409,477		10,409,477	1,610,071	12,019,548		29

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

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

Facility Name & ID Number Bel-Wood Nursing Home

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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			242,604	242,604		242,604	38,862	281,466			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			61,050	61,050		61,050		61,050			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			303,654	303,654		303,654	38,862	342,516			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		152,271	591,245	743,516		743,516	(33,461)	710,055			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			763,722	763,722		763,722		763,722			42
43	Other (specify):* <b>Non-Allowable Co</b>			289,486	289,486		289,486	(289,486)				43
44	<b>TOTAL Special Cost Centers</b>		152,271	1,644,453	1,796,724		1,796,724	(322,947)	1,473,777			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	7,090,691	1,267,338	4,151,826	12,509,855		12,509,855	1,325,986	13,835,841			45

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

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**VI. ADJUSTMENT DETAIL**

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	37,986	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(266,546)	43		24
25	Fund Raising, Advertising and Promotional	(23,794)	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 Pg 5A	(72,835)	Var.		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (325,189)		\$	30

BHF USE ONLY						
48		49		50		51
						52

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)	1,651,175		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 1,651,175		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 1,325,986		37

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

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

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

Bel-Wood Nursing Home

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Offset meal revenue	\$ (10,370)	2	1
2	Vending Machine Revenue	(6,127)	2	2
3	Loss on disposition of assets	788	43	3
4	Disallow Medicare Ancillary Costs	(33,461)	39	4
5	Employee Recognitions & Awards	(938)	22	5
6	Donations/Charitable	66	43	6
7	Disallow Cable TV	(19,775)	21	7
8	Disallow Phone	(369)	21	8
9	Disallow Out of State Travel	(2,151)	24	9
10	Disallow Out of State Seminars	(2,998)	24	10
11	To bring in adjustment from client for Medical			11
12	Records Consultant	2,500		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
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28				28
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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>		(72,835)	49

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Peoria County	100			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:	
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		Peoria County	100.00%	\$ 6,213	\$ 6,213	1
2	V	17	225,952	Peoria County	100.00%		(225,952)	2
3	V	18		Peoria County	100.00%	98,041	98,041	3
4	V	19	144,768	Peoria County	100.00%	321,257	176,489	4
5	V	21		Peoria County	100.00%	586,179	586,179	5
6	V	22		Peoria County	100.00%	1,234,745	1,234,745	6
7	V	22	10,250	Peoria County	100.00%	7,551	(2,699)	7
8	V	22	194,282	Peoria County	100.00%	143,118	(51,164)	8
9	V	22	651,426	Peoria County	100.00%	479,873	(171,553)	9
10	V	30		Peoria County	100.00%	876	876	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,226,678			\$ 2,877,853	\$ * 1,651,175	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: 01/01/12 Ending: 12/31/12

## 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	Lynn Scott Pearson	Chairperson	Administrative	0.00	N/A	1	<1%	N/A	\$ N/A	N/A	1
2	Bonnie J. Hester	Vice-Chairperson	Administrative	0.00	N/A	1	<1%	N/A	N/A	N/A	2
3	Brian Elsasser	Member	Administrative	0.00	N/A	1	<1%	N/A	N/A	N/A	3
4	Robert Baietto	Member	Administrative	0.00	N/A	1	<1%	N/A	N/A	N/A	4
5	Mary Ardapple	Member	Administrative	0.00	N/A	1	<1%	N/A	N/A	N/A	5
6	James Fennell	Member	Administrative	0.00	N/A	1	<1%	N/A	N/A	N/A	6
7	Phillip Salzer	Member	Administrative	0.00	N/A	1	<1%	N/A	N/A	N/A	7
8											8
9											9
10	Andrew Rand, a member of the Peoria County Board, is CEO of Advanced Medical Transport (AMT). Bel-Wood uses AMT in the transportation of residents.										10
11	Mr. Rand is not a member of the Health,Environmental and Welfare Issues Committee Board, which directly oversees Bel-Wood Nursing Home.										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

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# 0004499

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01/01/12

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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 Room 501, Peoria County Courthouse  
 City / State / Zip Code Peoria, IL 61602  
 Phone Number (309) 672-6056  
 Fax Number (309) 672-6065

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	1				\$ 6,213	1
2	18	County Board	Maximus, Inc. Please	1				98,041	2
3	19	Professional Services	see attached schedule.	1				176,489	3
4	21	Clerical Services	Further detail	1				586,179	4
5	22	Employee Benefits-Health	available upon	1				(171,553)	5
6	22	Employee Benefits-Work Comp	request.	1				(51,164)	6
7	22	Employee Benefits-U/C		1				(2,699)	7
8		Equipment Depreciation						876	8
9									9
10	17	Management Fee	Direct Cost					(225,952)	10
11	22	IMRF	Direct Cost					712,324	11
12	22	FICA	Direct Cost					522,421	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				\$	\$		\$ 1,651,175	25



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

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>				
1. Real Estate Tax accrual used on 2011 report.			\$		1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2011		\$		2	
3. Under or (over) accrual (line 2 minus line 1).			\$		3	
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)			\$		4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$		5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$		7	
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2007	_____	8	<b>FOR BHF USE ONLY</b>		
	2008	_____	9			
	2009	_____	10			
	2010	_____	11			
	2011	<u>N/A</u>	12			
<u>County facility-pays no real estate tax.</u>						
				13	FROM R. E. TAX STATEMENT FOR 2011 \$	13
				14	PLUS APPEAL COST FROM LINE 5 \$	14
				15	LESS REFUND FROM LINE 6 \$	15
				16	AMOUNT TO USE FOR RATE CALCULATION \$	16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

## 2011 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 Joyce Harmon

TELEPHONE (309) 677-6233 FAX #: (309) 495-4608

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2011 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 2011.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>County facility- pays no real estate tax.</u>	<u></u>	\$ <u></u>	\$ <u></u>
2.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
		<b>TOTALS</b>	\$ <u><u></u></u>	\$ <u><u></u></u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?                 YES                 NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

**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:

01/01/12 Ending:

12/31/12

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

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# 0004499

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	300	1969	1969	\$ 3,123,273	\$ 62,471	50	\$ 62,471	\$	\$ 2,748,508	4
5		1975	1975	4,223	92	45	92		3,557	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		9,512	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 (12,656 disposed 2011)		1989	145,485		Various			145,485	17
18	Improvements		1990	140,837		Various			140,837	18
19	Improvements		1991	599,124	29,956	Various	29,956		562,679	19
20	Improvements		1992	188,119		Various			188,119	20
21	Improvements		1995	4,885	244	16-20	244		4,207	21
22	Building Improvements (2009 - disposal of 8774)		1995	14,869		5-20			14,869	22
23	Resurface Driveway		1996	2,947	184	16	184		2,852	23
24	Telephone Wiring		1996	2,383	119	20	119		1,825	24
25	Faucets		1997	1,862	93	20	93		1,403	25
26	Replace Floor		1997	1,035	52	20	52		784	26
27	Remodeling		1997	1,291	65	20	65		1,007	27
28	Door Replacement		1997	4,957	248	20	248		3,927	28
29	Ceiling tile		1997	1,488	28	15	28		1,488	29
30	Concrete Slabs		1997	825	41	20	41		639	30
31	Sinks		1997	3,718	186	20	186		2,867	31
32	Plumbing		1997	2,397	96	25	96		1,480	32
33	Compressor (disposed of in 2009)		1997							33
34	Fireplace		1998	946	47	20	47		682	34
35	Bi-fold Doors		1998	27,343		10			27,343	35
36	Sink System		1998	2,569	128	20	128		1,878	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

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## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Handrails	1998	\$ 1,955	\$	10	\$	\$	\$ 1,955	37
38	Water Softener	1998	34,106		12			34,106	38
39	Roof Repair (Disposed 2011)								39
40	Wallpaper	1998	985	49	20	49		716	40
41	Wallpaper	1998	1,885	94	20	94		1,380	41
42	Wallpaper	1998	1,075	54	20	54		795	42
43	Wallpaper	1998	434	22		22		314	43
44	Roof Repair (Disposed 2011)								44
45	Underground Storage Tank	1998	26,041	651	40	651		9,765	45
46	Energy Management System Modifications	1999	3,732		10			3,732	46
47	Roof Repairs	2000	1,254	84	15	84		1,133	47
48	Architect fees per IDPA review of 1999 cost report	2000	15,290		8			15,290	48
49	Shelving, dish room	2000	1,500	75	20	75		956	49
50	Door relocation	2000	1,461	73	20	73		925	50
51	Roof Repairs	2000	3,552	237	15	237		2,981	51
52	Water Main #1	2000	3,178	127	25	127		1,588	52
53	Sidewalk Replacement	2000	1,350	68	20	68		849	53
54	Water Main #2	2000	2,120	85	25	85		1,047	54
55	Door guards	2000	1,694	85	20	85		1,040	55
56	Door, magnetic lock	2000	4,062	203	20	203		2,470	56
57	Replacement glass	2001	2,971	149	20	149		1,774	57
58	Fire System (Disposed 2011)								58
59	Water heater replacement	2001	84,666		8			84,666	59
60	Drawer front machine	2001	1,690	113	15	113		1,327	60
61	Windows	2002	59,439	2,972	20	2,972		30,463	61
62	Resident Alarm System	2002	43,538	2,177	20	2,177		21,951	62
63	Exit Device	2002	1,862	186	10	186		1,860	63
64	Egress Bars for Doors	2002	2,630	241	10	241		2,630	64
65	Rooftop Unit Pilot Program Phase 1	2002	1,420	95	15	95		950	65
66	Construction Documents	2002	6,750		8			6,750	66
67	Control Wiring	2002	2,495	125	20	125		1,323	67
68	Roof Repairs	2002	1,642	109	15	109		1,172	68
69	Exit Signs	2003	2,596	260	10	260		2,578	69
70	TOTAL (lines 4 thru 69)		\$ 5,466,626	\$ 102,653		\$ 102,653	\$	\$ 4,968,260	70

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

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## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,466,626	\$ 102,653		\$ 102,653	\$	\$ 4,968,260	1
2	Air Cylinder - Drain	2003	1,049	105	10	105		1,015	2
3	Zone Motor & Bases	2003	4,211	421	10	421		3,929	3
4	Construction Documentation	2003	12,854		8			12,854	4
5	Fence for Alzheimer Unit	2003	4,277	285	15	285		2,637	5
6	Parking lot overlay	2003	39,414	2,463	16	2,463		22,785	6
7	Water heater replacement	2003	52,500	3,500	15	3,500		32,375	7
8	Engineering	2003	3,700		8			3,700	8
9	Water main replacement	2003	80,810	3,232	25	3,232		29,359	9
10	Fire alarm panel replacement	2003	22,710	1,136	20	1,136		10,317	10
11	Reception Area Remodel	2003	2,904	145	20	145		1,306	11
12	Double Egress Doors	2004	2,585	259	10	259		2,199	12
13	Alzheimer Security	2004	26,381		5			26,381	13
14	Wallpaper HC & Norwood	2004	3,237		5			3,237	14
15	Blinds HC & Glasford	2004	6,070		5			6,070	15
16	Fire Alarm system	2004	111,652	11,165	10	11,165		93,043	16
17	Aluminum Awning (disposed of in 2009)	2004			10				17
18	Roof Repairs	2004	3,383	338	10	338		2,733	18
19	Fire alarm wiring	2004	5,812	581	10	581		4,649	19
20	Electrical service	2004	3,132	313	10	313		2,531	20
21	Compressor repairs (Disposed 2011)								21
22	Reception area shades	2004	2,062		5			2,062	22
23	Addition to watermain	2004	30,505	1,271	24	1,271		11,121	23
24	Door closer and locks	2004	2,366	237	10	237		2,071	24
25	Water heater replacement	2005	1,204		5			1,204	25
26	Roof Repairs - Massey	2005	15,793	1,579	10	1,579		11,185	26
27	Engine Control Panel	2005	35,025	1,751	20	1,751		13,425	27
28	Door closer and locks	2005	899	90	10	90		637	28
29	Carpeting	2005	1,735		5			1,735	29
30	Sink Repairs	2005	5,514		5			5,514	30
31	AA D379 Engine Repair (Disposed 2011)								31
32	Front Door Repair	2005	1,235		5			1,235	32
33	Carpeting	2005	1,563		5			1,563	33
34	TOTAL (lines 1 thru 33)		\$ 5,951,208	\$ 131,525		\$ 131,525	\$	\$ 5,281,132	34

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

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

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## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 5,951,208	\$ 131,525		\$ 131,525	\$	\$ 5,281,132	1
2	C-wing Faux Wood Blinds	2005	4,998		5			4,998	2
3	Water Softener Overhaul	2005	1,574		5			1,574	3
4	Smoke Detector	2005	1,710	171	10	171		1,354	4
5	4 Plexiglass Flower Boxes	2005	1,580		5			1,580	5
6	Domestic Hot Water Temp Valve (Disposed 2011)								6
7	Carpeting	2005	7,333		5			7,333	7
8	HVAC Repairs	2005	103,550		5			103,550	8
9	Booster Pump	2006	4,000		5			4,000	9
10	Doors and Locks	2006	8,760		5			8,760	10
11	Door Latch Replacement	2006	28,360		5			28,360	11
12	Roof Repairs (Disposed 2011)								12
13	HVAC Repairs (Disposed 2011)								13
14	Victory chiller swing door	2007	9,573	957	10	957		4,785	14
15	HVAC repairs	2007	44,128		3			44,128	15
16	Roof repairs	2007	9,240		3			9,240	16
17	Electrical upgrade	2007	42,840	4,284	10	4,284		21,420	17
18	Boiler pump	2007	3,274	654	5	654		3,274	18
19	Smoke dampers	2007	31,696	3,170	10	3,170		15,850	19
20	Fire Alarm	2007	6,770	677	10	677		3,891	20
21	Water back flows	2007	3,977	200	5	200		3,977	21
22	Outdoor walk-in freezer	2007	22,300	2,230	10	2,230		12,823	22
23	Carpeting	2007	3,172	213	5	213		3,172	23
24	Draper shades for hallway	2007	9,820	982	5	982		9,820	24
25	Disposal (disposed of in 2009)	2007							25
26	Front Door Patient Alarm	2007	2,580	301	5	301		2,580	26
27	Firewall for IDPH	2007	3,450	517	5	517		3,450	27
28	Booster Pump	2007	47,390	7,898	5	7,898		47,390	28
29	Ceiling Tile Replacement	2007	15,493	2,581	5	2,581		15,493	29
30	Sidewalks	2007	4,060	406	10	406		2,233	30
31	Main Entrance Delayed Exit A	2008	3,415		3			3,415	31
32	HVAC Repairs	2008	64,942		3			64,942	32
33	Roof Repairs	2008	8,308		3			8,308	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,449,501	\$ 156,766		\$ 156,766	\$	\$ 5,722,832	34

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

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## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 6,449,501	\$ 156,766		\$ 156,766	\$	\$ 5,722,832	1
2	Boiler Replacement	2008	18,200		3			18,200	2
3	Hot Water Heater Repairs	2008	3,606		3			3,606	3
4	Faux Wood Blinds	2008	22,596		3			22,596	4
5									5
6	HVAC Repairs	2009	76,683		2			76,683	6
7	Roof Repairs	2009	14,328		2			14,328	7
8	Flooring - First Floor	2009	4,657		2			4,657	8
9									9
10	Hammerall Disposer 3HP	2010	7,430	619	2	619		7,430	10
11	HVAC Repairs	2010	45,296	22,648	2	22,648		45,296	11
12	Roof Repairs	2010	8,789	4,394	2	4,394		8,789	12
13	Fusible Link/Booster heater	2010	6,539	354	2	354		6,539	13
14	Emergency Pump Repair	2010	3,154	920	2	920		3,154	14
15	Fauxwood Blinds	2010	2,773	1,039	2	1,039		2,773	15
16	Sidewalk Repair	2010	2,675	445	2	445		2,675	16
17									17
18	Boiler repair	2011	17,515	3,503	5	3,503		4,087	18
19	2011 HVAC repairs	2011	27,814	9,271	3	9,271	0	13,907	19
20	New Corridor doors	2011	4,460	892	5	892		1,487	20
21	Repipe Cold water	2011	2,556	511	5	511	0	554	21
22	2011 roof repairs	2011	11,990	2,398	5	2,398		3,597	22
23	Wet Sprinkler systems	2011	4,965	993	5	993		1,076	23
24	UPS	2011	2,558	512	5	512		683	24
25									25
26	HVAC Repairs - RTU 13, RTU 3, RTU 7 & RTU 5	2012	67,764		5	6,776	6,776	6,776	26
27	Roof Repairs - Whole Facility	2012	17,629		5	1,763	1,763	1,763	27
28	Accoustical Tile Repair - Therapy Room	2012	3,600	360	5	360		360	28
29									29
30									30
31	Adjust to financial statement information			(29,447)			29,447		31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,827,078	\$ 176,178		\$ 214,164	\$ 37,987	\$ 5,973,848	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 431,176	\$ 53,470	\$ 53,470	\$	5	\$ 305,438	71
72	Current Year Purchases	18,645	1,978	1,978		5	1,978	72
73	Fully Depreciated Assets	641,945	8,714	8,714		5	641,945	73
74	Allocated from Peoria County			876	876			74
75	TOTALS	\$ 1,091,766	\$ 64,162	\$ 65,038	\$ 876		\$ 949,361	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Maintenance	2000 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	Facility Maintenance	2012 Ford F-250 4X2	2012	27,165	2,264	2,264		5	2,264	78
79										79
80	TOTALS			\$ 83,864	\$ 2,264	\$ 2,264	\$		\$ 58,963	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)	\$ 8,002,808	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 242,604	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 281,466	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 38,862	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,982,172	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	CIP - New Building	\$ 39,293,541	92
93	CIP - Fixture & Furniture	675,978	93
94			94
95		\$ 39,969,519	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.

Facility Name & ID Number Bel-Wood Nursing Home

# 0004499

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Ending: 12/31/12

**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

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. \_\_\_\_\_ /2013 \$ \_\_\_\_\_

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

14. \_\_\_\_\_ /2015 \$ \_\_\_\_\_

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: \$ 61,050 Description: Medical Equipment - 47,361; Duplicating Equipment - 7,974; Software Maint/Lease 5,715.

(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			\$ <u>N/A</u>	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

Facility Name & ID Number Bel-Wood Nursing Home # 0004499 Report Period Beginning: 01/01/12 Ending: 12/31/12  
**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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	39(2),(3)	hrs	\$	3,825	\$ 221,018	\$ 1,332	3,825	\$ 222,350	1	
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,832	99,280		1,832	99,280	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	39(3)	hrs		4,938	237,486		4,938	237,486	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				150,939		150,939	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify):									12	
13	Other (specify):									13	
14	<b>TOTAL</b>			\$	10,595	\$ 557,784	\$ 152,271	10,595	\$ 710,055	14	

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

Facility Name & ID Number Bel-Wood Nursing Home # 0004499 Report Period Beginning: 01/01/12 Ending: 12/31/12  
 XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/12 (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	\$ 7,408,734	\$ 7,408,734	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>321,000</u> )	2,353,798	2,353,798	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments	3,000,000	3,000,000	5
6	Prepaid Insurance	103,340	103,340	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>	\$ 12,865,872	\$ 12,865,872	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	7,649,924	7,649,924	12
13	Land	821,367	100	13
14	Buildings, at Historical Cost	6,419,839	3,174,647	14
15	Leasehold Improvements, at Historical Cost	168,322	3,652,431	15
16	Equipment, at Historical Cost	1,175,630	1,175,630	16
17	Accumulated Depreciation (book methods)	(6,780,682)	(6,982,172)	17
18	Deferred Charges	6,711	6,711	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 <u>CIP</u> )	39,969,519	39,969,519	22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 49,430,630	\$ 48,646,790	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 62,296,502	\$ 61,512,662	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 3,742,781	\$ 3,742,781	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	161,449	161,449	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	79,253	79,253	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Schedule 17A</u>	602,625	602,625	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 4,586,108	\$ 4,586,108	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	42,000,000	42,000,000	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>	\$ 42,000,000	\$ 42,000,000	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 46,586,108	\$ 46,586,108	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 15,710,394	\$ 14,926,554	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 62,296,502	\$ 61,512,662	48

\*(See instructions.)

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

Supplementary Information

Schedule 17A

XV. BALANCE SHEET - Line 36 - Other Current Liabilities

	Operating	After Consolidation
Accrued Vacation & Comp Time	263,729	263,729
Due to State of Illinois	242,896	242,896
Deferred Revenue	96,000	96,000
Total P17 L 36	<u>602,625</u>	<u>602,625</u>

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>14,907,875</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>14,907,875</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	802,519	<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>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>802,519</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>15,710,394</b>	<b>24</b> *

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

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

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

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

		1	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 12,470,958	1
2	Discounts and Allowances for all Levels	(2,428,069)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 10,042,889	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	947,265	6
7	Oxygen	97,660	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,044,925	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	149,970	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>	\$ 149,970	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	1,382	24
25	Interest and Other Investment Income***	21,057	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 22,439	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a	<u>See Schedule 19A</u>	2,052,151	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 2,052,151	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 13,312,374	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	2,359,942	31
32	Health Care	6,246,055	32
33	General Administration	1,803,480	33
<b>B. Capital Expense</b>			
34	Ownership	303,654	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,033,002	35
36	Provider Participation Fee	763,722	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 12,509,855	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	802,519	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 802,519	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 5,932,580	44
45	Private Pay - Net Inpatient Revenue	2,112,682	45
46	Medicare - Net Inpatient Revenue	1,291,133	46
47	Other-(specify) <u>Third Party</u>	706,494	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 10,042,889	49

\* 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.

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

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

^ - Part of County. No return required.

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

Supplementary Information

Schedule 19A

XVII. INCOME STATEMENT - Line 28a - Other Revenue

	<u>Amount</u>
Miscellaneous Fee for Services	14,575
Property Tax	1,694,698
Vending Machines	6,127
Recovery of Bad Debts	100,203
Copies	181
Federal Grant	<u>236,367</u>
Total P19 L 28a	<u><u>2,052,151</u></u>

Facility Name & ID Number Bel-Wood Nursing Home

# 0004499

Report Period Beginning:

01/01/12

Ending:

12/31/12

**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	1,821	2,081	\$ 95,905	\$ 46.09	1
2	Assistant Director of Nursing	3,748	4,162	133,696	32.12	2
3	Registered Nurses	12,536	14,081	373,088	26.50	3
4	Licensed Practical Nurses	58,829	74,296	1,500,560	20.20	4
5	CNAs & Orderlies	170,299	194,793	2,736,458	14.05	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,774	2,081	51,501	24.75	9
10	Activity Assistants	9,581	12,946	236,767	18.29	10
11	Social Service Workers	4,670	5,659	134,723	23.81	11
12	Dietician					12
13	Food Service Supervisor	1,848	2,081	63,941	30.73	13
14	Head Cook	1,920	3,951	56,098	14.20	14
15	Cook Helpers/Assistants	35,706	43,096	541,035	12.55	15
16	Dishwashers					16
17	Maintenance Workers	5,250	6,028	119,751	19.87	17
18	Housekeepers	25,547	29,685	394,085	13.28	18
19	Laundry	11,686	13,143	163,459	12.44	19
20	Administrator	1,870	2,081	124,284	59.72	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,426	18,890	328,804	17.41	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,217	2,348	36,536	15.56	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	365,728	431,402	\$ 7,090,691 *	\$ 16.44	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 5,002	9(3)	36
37	Medical Records Consultant	Monthly 1,870	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			44
45	Social Service Consultant	Monthly 640	12(3)	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 7,512		49

**C. CONTRACT NURSES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	671 \$ 19,228	10(3)	50
51	Licensed Practical Nurses	9,328 273,351	10(3)	51
52	Certified Nurse Assistants/Aides	6,015 96,610	10(3)	52
53	TOTAL (lines 50 - 52)	16,014 \$ 389,189		53

Facility Name & ID Number Bel-Wood Nursing Home

# 0004499

Report Period Beginning: 01/01/12

Ending: 12/31/12

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
<u>Matt Niekirk</u>	<u>Administrator</u>	<u>0</u>	<u>\$ 124,284</u>	<u>Workers' Compensation Insurance</u>	<u>\$ 143,118</u>	<u>IDPH License Fee</u>	<u>\$ 1,990</u>	
				<u>Unemployment Compensation Insurance</u>	<u>7,551</u>	<u>Advertising: Employee Recruitment</u>	<u>6,288</u>	
				<u>FICA Taxes</u>	<u>522,421</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>479,873</u>	<u>(Indicate # of checks performed <u>11</u>)</u>		
				<u>Employee Meals</u>		<u>Patient Background Checks <u>191</u></u>	<u>2,000</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>	<u>712,324</u>	<u>Life Services Network of Illinois dues</u>	<u>8,851</u>	
						<u>Miscellaneous Dues &amp; Subscriptions</u>	<u>942</u>	
						<u>Miscellaneous Fees</u>	<u>260</u>	
<b>TOTAL (agree to Schedule V, line 17, col. 1)</b>			<b>\$ 124,284</b>					
<b>(List each licensed administrator separately.)</b>								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
<u>Peoria County (Management Fee)</u>			<u>\$ 225,952</u>	<u>N/A</u>			<u>Out-of-State Travel</u>	<u>\$ 0</u>
<u>Eliminated on P3, L17 C7</u>								
							<u>In-State Travel</u>	<u>5,783</u>
							<u>Seminar Expense</u>	<u>4,338</u>
							<u>Entertainment Expense</u>	<u>( )</u>
<b>TOTAL (agree to Schedule V, line 17, col. 3)</b>			<b>\$ 225,952</b>	<b>TOTAL (agree to Schedule V, line 22, col.8)</b>			<b>TOTAL (agree to Sch. V, line 20, col. 8)</b>	
<b>(Attach a copy of any management service agreement)</b>						<b>\$ 1,865,287</b>		<b>\$ 20,331</b>
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
<u>McGladrey LLP</u>	<u>Accounting</u>		<u>\$ 11,400</u>					
<u>E-Health Data Solutions</u>	<u>Data Management</u>		<u>9,612</u>					
<u>Curaspan Healthgroup</u>	<u>Data Management</u>		<u>2,250</u>					
<u>Peoria County</u>	<u>Data Processing</u>		<u>144,768</u>					
<u>Avalon Global Solutions</u>	<u>IT Consulting</u>		<u>500</u>					
<b>TOTAL (agree to Schedule V, line 19, column 3)</b>			<b>\$ 168,530</b>	<b>TOTAL</b>				
<b>(If total legal fees exceed \$5,000, attach copy of invoices.)</b>						<b>\$</b>		

\* Attach copy of IMRF notifications

\*\*See instructions.

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

Schedule 21A

XIXI. Support Schedules - Section - Professional Services

	<u>Amount</u>
Per Schedule V, L19, C3	168,530
County Allocation	176,489
Per Schedule V, L19, C8	<u>345,019</u>

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

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

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

Report Period Beginning:

01/01/12

Ending:

12/31/12**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-\$8,851
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 5 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 160,786 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. \$ 763,722  
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. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 10,370
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? Yes  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 0  
d. Have vehicle usage logs been maintained? 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: Baker Tilly
- (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.