

Facility Name & ID Number BELLWOOD DEVELOPMENTAL CTR

0051904 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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 _____

	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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	82	Intermediate/DD	82	29,930	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	82	TOTALS	82	29,930	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	28,151	366	0	28,517	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,151	366		28,517	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.28%

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)

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 3/1/2012

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

YES Date 3/1/2012 NO

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

YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2013 Fiscal Year: 12/31/2013

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	205,815	18,338	7,776	231,929		231,929		231,929		1
2	Food Purchase		151,819		151,819		151,819		151,819		2
3	Housekeeping	169,852	19,708		189,560		189,560		189,560		3
4	Laundry	74,655	4,512		79,167		79,167		79,167		4
5	Heat and Other Utilities			104,592	104,592		104,592	(142)	104,450		5
6	Maintenance	30,900		64,306	95,206		95,206		95,206		6
7	Other (specify):*										7
8	TOTAL General Services	481,222	194,377	176,674	852,273		852,273	(142)	852,131		8
	B. Health Care and Programs										
9	Medical Director			13,200	13,200		13,200		13,200		9
10	Nursing and Medical Records	1,324,423	91,841	74,517	1,490,781		1,490,781		1,490,781		10
10a	Therapy			6,545	6,545		6,545		6,545		10a
11	Activities	98,800	3,539		102,339		102,339		102,339		11
12	Social Services	53,340			53,340		53,340		53,340		12
13	CNA Training										13
14	Program Transportation			10,776	10,776		10,776		10,776		14
15	Other (specify):* CASE MANAGERS	141,516			141,516		141,516		141,516		15
16	TOTAL Health Care and Programs	1,618,079	95,380	105,038	1,818,497		1,818,497		1,818,497		16
	C. General Administration										
17	Administrative	305,597		60,577	366,174		366,174		366,174		17
18	Directors Fees										18
19	Professional Services			76,622	76,622		76,622		76,622		19
20	Dues, Fees, Subscriptions & Promotions			14,599	14,599		14,599	(7,981)	6,618		20
21	Clerical & General Office Expenses	49,714	13,386	22,062	85,162		85,162		85,162		21
22	Employee Benefits & Payroll Taxes			417,506	417,506		417,506		417,506		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,212	3,212		3,212		3,212		24
25	Other Admin. Staff Transportation			9,056	9,056		9,056		9,056		25
26	Insurance-Prop.Liab.Malpractice			45,106	45,106		45,106		45,106		26
27	Other (specify):* IDPH Expense			975	975		975	(975)			27
28	TOTAL General Administration	355,311	13,386	649,715	1,018,412		1,018,412	(8,956)	1,009,456		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,454,612	303,143	931,427	3,689,182		3,689,182	(9,098)	3,680,084		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

BELLWOOD DEVELOPMENTAL CTR

#0051904

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			76,237	76,237		76,237		76,237			30
31	Amortization of Pre-Op. & Org.			46,649	46,649		46,649	(46,649)				31
32	Interest			192,747	192,747		192,747		192,747			32
33	Real Estate Taxes			147,311	147,311		147,311		147,311			33
34	Rent-Facility & Grounds			30,000	30,000		30,000		30,000			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* INCOME TAX			5,950	5,950		5,950	(5,949)	1			36
37	TOTAL Ownership			498,894	498,894		498,894	(52,598)	446,296			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			283,584	283,584		283,584		283,584			42
43	Other (specify):* DT EXPENSE/MISC			1,486,748	1,486,748		1,486,748		1,486,748			43
44	TOTAL Special Cost Centers			1,770,332	1,770,332		1,770,332		1,770,332			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,454,612	303,143	3,200,653	5,958,408		5,958,408	(61,696)	5,896,712			45

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

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-	BHF USE	
			ence	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	(142)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				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	(975)	27		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				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(5,949)	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(7,981)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (15,047)		\$	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	(46,649)	31	33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (46,649)		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (61,696)		37

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

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

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

BELLWOOD DEVELOPMENTAL CTR

ID# 0051904

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BELLWOOD DEVELOPMENTAL CTR# 0051904

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(142)	0	0	0	0	0	0	0	0	0	0	(142)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(142)	0	0	0	0	0	0	0	0	0	0	(142)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(7,981)	0	0	0	0	0	0	0	0	0	0	(7,981)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(975)	0	0	0	0	0	0	0	0	0	0	(975)	27
28	TOTAL General Administration	(8,956)	0	0	0	0	0	0	0	0	0	0	(8,956)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(9,098)	0	0	0	0	0	0	0	0	0	0	(9,098)	29

STATE OF ILLINOIS

Facility Name & ID Number BELLWOOD DEVELOPMENTAL CTR# 0051904

Report Period Beginning:

01/01/2013 Ending:

Summary B

12/31/2013

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	(46,649)	0	0	0	0	0	0	0	0	0	0	(46,649)	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(5,949)	0	0	0	0	0	0	0	0	0	0	(5,949)	36
37	TOTAL Ownership	(52,598)	0	0	0	0	0	0	0	0	0	0	(52,598)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(61,696)	0	0	0	0	0	0	0	0	0	0	(61,696)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
MICHAEL NUDELL	25%	STOCKTON HEALTHCARE & REHAB INC	STOCKTON, IL			
YEHUDIT GOLDBERG	25%	WILLOW OF MARENGO	MARENGO, IL			
ZVI FEINER	5%	ELMWOOD TERRACE HEALTHCARE CENTER	AURORA, IL			
JOSEPH BRANDMAN (Custodian for children)	45%	CRESTVIEW NURSING & REHABILITATION	WEBSTER CITY, IA			
		CAMBRIDGE HEALTHCARE & REHABILITATION	CAMBRIDGE, OH			
		BARNESVILLE HEALTHCARE & REHABILITATION	BARNESVILLE, OH			

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item							
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

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

Facility Name & ID Number

BELLWOOD DEVELOPMENTAL CTR

0051904

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number BELLWOOD DEVELOPMENTAL CTR # 0051904 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	JOSEPH BRANDMAN	SHAREHOLDER	MANAGEMENT	0.45		11	25.00	SALARY	\$ 50,000	17-1	1
2	MICHAEL NUDELL	SHAREHOLDER	MANAGEMENT	0.25		20	50.00	SALARY	80,000	17-1	2
3	YEHUDIT GOLDBERG	SHAREHOLDER	MANAGEMENT	0.25		0	0.00		0		3
4	ZVI FEINER	SHAREHOLDER	DIRECTOR	0.25		0	0.00		0		4
5	JEREMY GOLDBERG	RELATIVE	MANAGEMENT	0.00		20	50.00	SALARY	80,000	17-1	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 210,000		13

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

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

Facility Name & ID Number BELLWOOD DEVELOPMENTAL CTR

0051904

Report Period Beginning: 01/01/2013

Ending: 2/31/2013

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
A. Directly Facility Related																	
Long-Term																	
1	PRIVATE BANK MORTGAGE		X	MORTGAGE	\$9,000.00	5/22/2012	\$ 2,150,000	\$ 2,150,000	5/31/2017	6.0000	\$ 130,433						
2	PAYABLE TO S. BRANDMAN	X		MORTGAGE		3/1/2012	2,500,000	450,000		12.2200	55,000						
3																	
4																	
5																	
Working Capital																	
6	LINE OF CREDIT		X	OPERATING EXPENSE		5/22/2013	1,600,000		5/22/2014	4.2500	7,249						
7	MEMBER LOAN	X		OPERATING EXPENSE		5/31/2013		50,000									
8	AFFILIATED COMPANY	X		OPERATING EXPENSE				25,500									
9	TOTAL Facility Related				\$9,000.00		\$ 6,250,000	\$ 2,675,500			\$ 192,682						
B. Non-Facility Related*																	
10																	
11																	
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$			\$						
15	TOTALS (line 9+line14)						\$ 6,250,000	\$ 2,675,500			\$ 192,682						

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

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

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

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																																
1. Real Estate Tax accrual used on 2012 report.		\$ 143,500	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.)		\$ 143,500	2																													
3. Under or (over) accrual (line 2 minus line 1).		\$	3																													
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 147,311	4																													
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5																													
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6																													
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 147,311	7																													
Real Estate Tax History:																																
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2008</td><td>_____</td><td>8</td></tr> <tr><td>2009</td><td>_____</td><td>9</td></tr> <tr><td>2010</td><td>_____</td><td>10</td></tr> <tr><td>2011</td><td>_____</td><td>11</td></tr> <tr><td>2012</td><td>_____</td><td>12</td></tr> </table>	2008	_____	8	2009	_____	9	2010	_____	10	2011	_____	11	2012	_____	12	<table border="1"> <tr><td colspan="2">FOR BHF USE ONLY</td><td></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2012 \$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5 \$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6 \$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION \$</td><td>16</td></tr> </table>	FOR BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2012 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
2008	_____	8																														
2009	_____	9																														
2010	_____	10																														
2011	_____	11																														
2012	_____	12																														
FOR BHF USE ONLY																																
13	FROM R. E. TAX STATEMENT FOR 2012 \$	13																														
14	PLUS APPEAL COST FROM LINE 5 \$	14																														
15	LESS REFUND FROM LINE 6 \$	15																														
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																														
WE ARE STILL WAITING ON A REAL ESTATE TAX BILL FROM 2012 WHEN THE FACILITY CHANGED OWNERSHIP. PLEASE SEE ATTACHED APPRAISAL REPORT AND CALCUATION.																																

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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BELLWOOD DEVELOPMENTAL CTR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0051904

CONTACT PERSON REGARDING THIS REPORT JESSICA KOPP

TELEPHONE 815-232-1324 FAX #: 815-235-1050

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2012 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 2012.

	(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>15-09-200-023</u>	<u></u>	\$ <u>147,311.00</u>	\$ <u>147,311.00</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>
		TOTALS	\$ <u><u>147,311.00</u></u>	\$ <u><u>147,311.00</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,330 B. General Construction Type: Exterior BRICK Frame WOOD Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

N/A

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: 699,736 2. Number of Years Over Which it is Being Amortized: 15
 3. Current Period Amortization: 46,649 4. Dates Incurred: 3/1/2012, 3/12/2012, 5/22/2012

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>NURSING HOME</u>	<u>196,000</u>	<u>2012</u>	<u>\$ 400,000</u>	1
2					2
3	TOTALS	196,000		\$ 400,000	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	82		2012		\$ 902,000	\$ 22,550	40	\$ 22,550	\$	\$ 41,342	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	BUILDING IMPROVEMENTS - SEE DETAIL BELOW		2013		334,151	2,088	40	2,088	(0)	2,088	9
10											10
11		FIRE COVERAGE FOR PATIENT ROOMS - \$28,350									11
12		LOBBY - \$28,117.39									12
13		CORRIDOR - \$103,884.39									13
14		LOUNGE - \$7,354.45									14
15		NURSES STATION - \$18,613.22									15
16		NURSING OFFICE - \$4,170.30									16
17		GUEST BATHROOMS - \$6,372.63									17
18		CONFERENCE ROOM - \$8,939.08									18
19		DINING ROOM - \$39,527.41									19
20		RESIDENT ROOMS - \$10,437.41									20
21		AREAS LISTED - \$47,030									21
22		FREIGHT - \$13,604.75									22
23		SALES TAX - \$18,023.29									23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*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

XI. OWNERSHIP COSTS (continued)

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

1		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			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,236,151	\$ 24,638		\$ 24,638	\$ (0)	\$ 43,430	70

**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	\$ 341,319	\$ 48,760	\$ 48,760	\$	7	\$ 88,810	71
72	Current Year Purchases	13,530	1,073	1,073	0	7	1,073	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 354,849	\$ 49,833	\$ 49,833	\$ 0		\$ 89,883	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	PATIENT TRANSPORT	2002 FORD E450 SUPER DUTY	2012	\$ 8,831	\$ 1,766	\$ 1,766	\$	5	\$ 2,061	76
77										77
78										78
79										79
80	TOTALS			\$ 8,831	\$ 1,766	\$ 1,766	\$		\$ 2,061	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)	\$ 1,999,831	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 76,237	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 76,237	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (0)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 135,374	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12. _____ /2014 \$ _____

13. _____ /2015 \$ _____

14. _____ /2016 \$ _____

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

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

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

Facility Name & ID Number BELLWOOD DEVELOPMENTAL CTR # 0051904 Report Period Beginning: 01/01/2013 Ending: 12/31/2013
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?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)		Total Units (Column 2 + 4)		Total Cost (Col. 3 + 5 + 6)					
			Units of Service	Cost	Units	Cost										
1	Licensed Occupational Therapist		hrs	\$		\$		\$								1
2	Licensed Speech and Language Development Therapist		hrs													2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist		hrs													4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy		# of prescrpts													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	TOTAL			\$		\$		\$								14

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

Facility Name & ID Number **BELLWOOD DEVELOPMENTAL CTR**# **0051904**Report Period Beginning: **01/01/2013**

Ending:

12/31/2013**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2013**

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 554,992	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	407,799		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	22,375		6
7	Other Prepaid Expenses	2,863		7
8	Accounts Receivable (owners or related parties)	58,628		8
9	Other(specify): EMPLOYEE ADVANCE	330		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,046,987	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	400,000		13
14	Buildings, at Historical Cost	902,000		14
15	Leasehold Improvements, at Historical Cost	334,151		15
16	Equipment, at Historical Cost	363,681		16
17	Accumulated Depreciation (book methods)	(135,374)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	699,736		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(84,729)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,479,465	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,526,452	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 197,565	\$	26
27	Officer's Accounts Payable	50,000		27
28	Accounts Payable-Patient Deposits	4,860		28
29	Short-Term Notes Payable	450,000		29
30	Accrued Salaries Payable	141,802		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,875		31
32	Accrued Real Estate Taxes(Sch.IX-B)	290,811		32
33	Accrued Interest Payable			33
34	Deferred Compensation	61,866		34
35	Federal and State Income Taxes	4,415		35
	Other Current Liabilities(specify):			
36	DUE TO AFFILIATED COMPANIES	25,500		36
37	OTHER MISC CURRENT	4,797		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,244,491	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,150,000		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,150,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,394,491	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 131,961	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,526,452	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 274,830	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 274,830	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	256,131	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(399,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (142,869)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 131,961	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,726,573	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,726,573	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	54	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 54	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)	19	27
28	DAY TRAINING INCOME	1,486,177	28
28a	VENDING & SCRAP SOLD	1,716	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,487,912	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,214,539	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	852,273	31
32	Health Care	1,818,497	32
33	General Administration	1,018,412	33
B. Capital Expense			
34	Ownership	498,894	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	283,584	36
D. Other Expenses (specify):			
37	<u>DAY TRAINING EXPENSE</u>	1,486,177	37
38	<u>INTEREST & PENALTIES</u>	171	38
39	<u>OTHER MISC</u>	400	39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,958,408	40
41	Income before Income Taxes (line 30 minus line 40)**	256,131	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 256,131	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 3,851,584	44
45	Private Pay - Net Inpatient Revenue	60,660	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <u>SSA/SSI</u>	629,319	47
48	Other-(specify) <u>HOSPICE</u>	185,010	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,726,573	49

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

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

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

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

Facility Name & ID Number **BELLWOOD DEVELOPMENTAL CTR**

0051904

Report Period Beginning: **01/01/2013**

Ending: **12/31/2013**

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	1,932	2,080	\$ 63,269	\$ 30.42	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,923	10,063	247,445	24.59	3
4	Licensed Practical Nurses	2,194	2,410	61,986	25.72	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,752	1,986	28,500	14.35	9
10	Activity Assistants	7,681	7,709	70,300	9.12	10
11	Social Service Workers	1,827	1,995	53,340	26.74	11
12	Dietician					12
13	Food Service Supervisor	821	984	17,549	17.83	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,274	18,931	188,266	9.94	15
16	Dishwashers					16
17	Maintenance Workers	1,880	2,116	30,900	14.60	17
18	Housekeepers	16,343	17,397	169,852	9.76	18
19	Laundry	1,794	6,274	74,655	11.90	19
20	Administrator	1,989	2,101	94,253	44.86	20
21	Assistant Administrator					21
22	Other Administrative			210,000		22
23	Office Manager					23
24	Clerical	4,315	4,441	46,016	10.36	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	72	72	1,008	14.00	28
29	Resident Services Coordinator	7,626	8,499	140,508	16.53	29
30	Habilitation Aides (DD Homes)	76,336	80,676	834,437	10.34	30
31	Medical Records					31
32	Other Health Care(specify)	7,215	7,937	118,628	14.95	32
33	Other(specify) <u>BONUS/JURY</u>			3,700		33
34	TOTAL (lines 1 - 33)	161,974	175,671	\$ 2,454,612 *	\$ 13.97	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	144	\$ 7,776	1-3	35
36	Medical Director	120	13,200	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	532	22,296	10-3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	96	6,545	10a-3	40
41	Occupational Therapy Consultant	198	9,875	10-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	118	7,755	10-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	<u>PSYCHIATRIC</u>	107	16,350	10-3	47
48	<u>DENTAL</u>	293	18,241	10-3	48
49	TOTAL (lines 35 - 48)	1,607	\$ 102,038		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
DAVID ZARUBA	ADMINISTRATOR	0	\$ 95,596	Workers' Compensation Insurance	\$ 58,975	IDPH License Fee	\$	
MICHAEL NUDELL	MANAGEMENT	25%	80,000	Unemployment Compensation Insurance	58,556	Advertising: Employee Recruitment	125	
JEREMY GOLDBERG	MANAGEMENT	25%	80,000	FICA Taxes	186,001	Health Care Worker Background Check	1,000	
JOSEPH BRANDMAN	MANAGEMENT	45%	50,000	Employee Health Insurance	103,842	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		ADVERTISING & PROMOTIONS	7,981	
				STAFF MEETINGS	3,232	OTHER MEMBERSHIP	110	
				UNION BONUS	6,900	GOVERNMENT CONTRACT	500	
						PROSPECT RESOURCES	750	
						IHCA DUES	4,133	
						Less: Public Relations Expense	()	
						Non-allowable advertising	(7,981)	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 305,596	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 417,506		\$ 6,618		
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
MANAGEMENT FEE TO ABS			\$ 60,577	N/A		\$	Out-of-State Travel	\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 60,577	TOTAL		\$	In-State Travel	
							TRAVEL EXPENSE	1,334
							Seminar Expense	
							PROFESSIONAL DEVELOPMENT	1,878
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 76,622	TOTAL		\$	TOTAL	\$ 3,212

* Attach copy of IMRF notifications

**See instructions.

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
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19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number BELLWOOD DEVELOPMENTAL CTR

0051904

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

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. IHCA \$4133
- (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? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 34,732 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 283,584
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? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? COMPILATION
Firm Name: THOMPSON & KOPP INC
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.