



Facility Name & ID Number BELMONT NURSING HOME

# 0024968 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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	61	Intermediate (ICF)	61	22,265	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	61	TOTALS	61	22,265	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	
8	SNF				8
9	SNF/PED				9
10	ICF	18,223			18,223
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	18,223			18,223

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.85%

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

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

NONE

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

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

YES  NO

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

YES  NO

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

Date started 10/16/79

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

YES  Date 10/16/79 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 0

Medicare Intermediary \_\_\_\_\_

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2015 Fiscal Year: 6/30/2015

\* 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
	<b>A. General Services</b>										
1	Dietary	132,507	28,508	2,736	163,751		163,751	163,751			1
2	Food Purchase		105,625		105,625	(4,599)	101,026	100,303			2
3	Housekeeping	60,983	38,110		99,093		99,093	99,093			3
4	Laundry										4
5	Heat and Other Utilities			35,361	35,361		35,361	35,361			5
6	Maintenance	47,574	36,401	1,397	85,372		85,372	85,372			6
7	Other (specify):* Scavenger			6,000	6,000		6,000	6,000			7
8	<b>TOTAL General Services</b>	241,064	208,644	45,494	495,202	(4,599)	490,603	489,880			8
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	538,779	45,723	41,981	626,483		626,483	626,483			10
10a	Therapy										10a
11	Activities	22,126	5,298		27,424		27,424	27,424			11
12	Social Services	19,751			19,751		19,751	19,751			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	580,656	51,021	41,981	673,658		673,658	673,658			16
	<b>C. General Administration</b>										
17	Administrative	210,325			210,325		210,325	210,325			17
18	Directors Fees										18
19	Professional Services			17,498	17,498		17,498	17,498			19
20	Dues, Fees, Subscriptions & Promotions			19,853	19,853		19,853	14,143	(5,710)		20
21	Clerical & General Office Expenses	46,800	66,208	2,518	115,526		115,526	115,526			21
22	Employee Benefits & Payroll Taxes			214,462	214,462	4,599	219,061	219,061			22
23	Inservice Training & Education			750	750		750	750			23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			33,446	33,446		33,446	33,446			26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	257,125	66,208	288,527	611,860	4,599	616,459	610,749	(5,710)		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,078,845	325,873	376,002	1,780,720		1,780,720	1,774,287	(6,433)		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.

V.COST CENTER EXPENSES

PAGE 3 COLUMN 3 OTHER

LINE	DIETARY	TOTAL	LINE	TOTAL
1	DIETITIAN CONSULTANT	2,736.00	21	CLERICAL & GENERAL OFFICE EXPENSES
		<u>2,736.00</u>		TELEPHONE 2,518.00
5	HEAT & OTHER UTILITIES			BANK CHARGE
	CABLE TV-LOBBY	974.00		EQUIPMENT REPAIRS & MAINT.
	UTILITIES	34,387.00		PENALTIES <u>2,518.00</u>
		<u>35,361.00</u>	22	EMPLOYEE BENEFITS & PAYROLL TAXES
6	MAINTENANCE			FICA TAXES 81,320.00
	EXTERMINATING SERVICE	1,397.00		UNEMPLOYMENT COMPENSATION 7,214.00
		<u>1,397.00</u>		WORKERS COMPENSATION INSURANCE 15,733.00
7	OTHER			HOSPITALIZATION INSURANCE 81,568.00
	SCAVENG	6,000.00		EMPLOYEE 401K 24,741.00
		<u>6,000.00</u>		EMPLOYEE BENEFIT - OTHER 988.00
10	NURSING			PENSION/PROFIT SHARING PLANS 2,898.00 <u>214,462.00</u>
	CONTRACT NURSING	38,345.00	23	INSERVICE TRAINING & EDUCATION
	PHARMACY CONSULTANT	3,636.00		EDUCATION & SEMINARS 750.00 <u>750.00</u>
		<u>41,981.00</u>	25	ADMIN. STAFF TRANSPORTATION
12	SOCIAL SERVICES			TRANSPORTATION - STAFF <u>-</u>
	SOCIAL WORKER	-	26	INSURANCE - PROP. LIAB & MALPRACTICE
19	PROFESSIONAL SERVICES			GENERAL INSURANCE 33,446.00 <u>33,446.00</u>
	DATA PROCESSING	839.00		
	PROFESSIONAL FEES	16,659.00		
		<u>17,498.00</u>		
20	FEES,SUBSCRIPTIONS,PROMOTIONS			
	POLITICAL CONTRIBUTIONS	5,710.00		
	DUES & SUBSCRIPTIONS	8,656.00		
	LICENSES & PERMITS	4,230.00		
	HEALTH CARE WORKER BACKGROUND CHEC			
	EMPLOYEE WANT ADS	1,257.00		
		<u>19,853.00</u>		
				Grand total column 3 other 376,002.00

**BELMONT NURSING HOME  
SCHEDULES  
06/30/2015**

**EMPLOYEE MEAL RECLASSIFICATION  
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22**

TOTAL FOOD PURCHASE	119,858
LESS SALES TAX	<u>(1,113)</u>
NET FOOD	118,745
TOTAL PATIENT CENSUS	18,113
TIMES 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	54,339
ADD # EMPLOYEE MEALS/DAY	6
TIMES # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	2,190
PATIENT MEALS	54,339
ADD EMPLOYEE MEALS	<u>2,190</u>
TOTAL MEALS/YEAR	56,529
NET FOOD	118,745
DIVIDE TOTAL MEALS/YEAR	<u>56,529</u>
COST PER MEAL	2.10
TIMES EMPLOYEE MEALS	<u>2,190</u>
EMPLOYEE MEAL RECLASSIFICATION	<u><u>4,599</u></u>

Facility Name & ID Number BELMONT NURSING HOME

#0024968

Report Period Beginning: 07/01/2014 Ending: 06/30/2015

## 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			22,292	22,292		22,292	29,828	52,120			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			17,994	17,994		17,994	(4)	17,990			32
33	Real Estate Taxes			50,068	50,068		50,068		50,068			33
34	Rent-Facility & Grounds			277,093	277,093		277,093		277,093			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			367,447	367,447		367,447	29,824	397,271			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>											44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,078,845	325,873	743,449	2,148,167		2,148,167	23,391	2,171,558			45

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

Facility Name & ID Number **BELMONT NURSING HOME**

# **0024968**

Report Period Beginning: **07/01/2014**

Ending: **06/30/2015**

**VI. ADJUSTMENT DETAIL**

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

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

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	29,828	30		9
10	Interest and Other Investment Income	(4)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(723)	2		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	(5,710)	20		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				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ 23,391		\$	30

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

		1	2	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 23,391		37

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

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

		1	2	3	4	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
38	Medically Necessary Transport.			\$		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

<b>BHF USE ONLY</b>						
48		49		50		51
						52

BELMONT NURSING HOME

ID# 0024968

Report Period Beginning: 07/01/2014

Ending: 06/30/2015

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	<b>Total</b>		0	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number BELMONT NURSING HOME

# 0024968

Report Period Beginning:

07/01/2014

Ending:

06/30/2015

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(723)	0	0	0	0	0	0	0	0	0	0	(723)	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	0	0	0	0	0	0	0	0	0	0	0	0	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	<b>TOTAL General Services</b>	<b>(723)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(723)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	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	(5,710)	0	0	0	0	0	0	0	0	0	0	(5,710)	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):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(5,710)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(5,710)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(6,433)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(6,433)</b>	<b>29</b>

## STATE OF ILLINOIS

Facility Name & ID Number BELMONT NURSING HOME# 0024968

Report Period Beginning:

07/01/2014 Ending:

Summary B

06/30/2015

## 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)	
	<b>D. Ownership</b>													
30	Depreciation	29,828	0	0	0	0	0	0	0	0	0	0	29,828	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4)	0	0	0	0	0	0	0	0	0	0	(4)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>29,824</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>29,824</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	23,391	0	0	0	0	0	0	0	0	0	0	23,391	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
EILEEN CONWAY	100					

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

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

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

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

**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 BELMONT NURSING HOME # 0024968 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

## 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	EILEEN CONWAY	PRESIDENT	FINANCE	100.00		40	100.00	SALARY	\$ 111,000	17-1	1
2			BANKING								2
3			PATIENT RELATIONS								3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 111,000		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 BELMONT NURSING HOME

# 0024968

Report Period Beginning: 07/01/2014

Ending: 6/30/2015

**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	<b>TOTALS</b>				\$	\$		\$	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 2014 report.		\$	<b>56,655</b>		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.)		\$	<b>56,655</b>		2														
3. Under or (over) accrual (line 2 minus line 1).		\$			3														
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>57,998</b>		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 \$ <u>7,930</u> For <u>2011</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	<b>(7,930)</b>		6														
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>50,068</b>		7														
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2010	<u>49,915</u>	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;"><b>FOR BHF USE ONLY</b></td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2014 \$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td style="text-align: center;">16</td> </tr> </table>		<b>FOR BHF USE ONLY</b>		13	FROM R. E. TAX STATEMENT FOR 2014 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
<b>FOR BHF USE ONLY</b>																			
13	FROM R. E. TAX STATEMENT FOR 2014 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
	2011	<u>49,707</u>	9																
	2012	<u>55,490</u>	10																
	2013	<u>56,242</u>	11																
	2014	<u>57,374</u>	12																
<b>REAL ESTATE TAX PAID IS THE 2013 2ND INSTALLMENT OF \$25,722 PLUS THE 2014 1ST INSTALLMENT OF \$30,933</b>																			
<b>REAL ESTATE TAX ACCRUAL 2014 2ND INSTALLMENT OF \$26,442 PLUS 55% OF 2014 REAL ESTATE TAX BILLS OF \$57,374.49 (\$31,556)= \$57,998</b>																			

**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.**

## 2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BELMONT NURSING HOME COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0024968

CONTACT PERSON REGARDING THIS REPORT SANFORD BOKOR

TELEPHONE (847)675-3585 FAX #: (847)675-5777

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

Enter the tax index number and real estate tax assessed for 2014 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 2014.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>14-19-432-030-0000</u>	<u>NURSING HOME</u>	\$ <u>11,850.55</u>	\$ <u>11,850.55</u>
2. <u>14-19-432-031-0000</u>	<u>NURSING HOME</u>	\$ <u>15,276.34</u>	\$ <u>15,276.34</u>
3. <u>14-19-432-032-0000</u>	<u>NURSING HOME</u>	\$ <u>30,247.60</u>	\$ <u>30,247.60</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>57,374.49</u></u>	\$ <u><u>57,374.49</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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

**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: 10,248 B. General Construction Type: Exterior BRICK Frame IRON & WOOD Number of Stories \_\_\_\_\_

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

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

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

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1		<u>15,624</u>		\$	1
2					2
3	TOTALS	15,624		\$	3

Facility Name &amp; ID Number BELMONT NURSING HOME

# 0024968

Report Period Beginning:

07/01/2014

Ending:

06/30/2015

**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			1979	1919	\$ 138,750	\$		\$	\$	\$ 138,750	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	VARIOUS			84	9,518		20			9,518	9
10	VARIOUS			88	4,145		20			4,145	10
11	VARIOUS			89	5,009		20			5,009	11
12	VARIOUS			83	5,000		20			5,000	12
13	VARIOUS			84	1,300		20			1,300	13
14	VARIOUS			82	5,000		20			5,000	14
15	ADDITIONS			93	72,104		20			72,104	15
16	RADIATOR COVERS			94	1,404		20			1,404	16
17	FAUCETS & COURTERS			94	2,192		20			2,192	17
18	PRIVACY SCREENS			94	2,182		20			2,182	18
19	REMODELING			94	89,471		20			89,471	19
20	HEATER			94	1,011		20			1,011	20
21	BREAKER PANELS			94	1,355		20			1,355	21
22	BREAKER PANELS			94	1,155		20			1,155	22
23	REMODELING			95	107,660		20	2,691	2,691	107,660	23
24	ROOF			96	4,921		20	246	246	4,763	24
25	GLASS BLOCK WINDOW, NEW A/C			96	30,000		20	1,500	1,500	29,268	25
26	REMOVE BRICK FENCE, REMOVE METAL OVERHANG			96	46,977		20	2,349	2,349	45,818	26
27	NEW WOOD OVERHANG, IRON RAILINGS, ETC			96	50,000		20	2,500	2,500	48,753	27
28	FURNACE			97	3,820		20	191	191	3,534	28
29	NEW CHIMNEYS, NEW DOWNSPROUTS, NEW FLOOR			97	30,000		20	1,500	1,500	27,734	29
30	FAUCETS & FLOORS, WINDOWS, HOT WATER HEATER			97	53,500		20	2,675	2,675	49,485	30
31	DRYWALL & DOORS IN BASEMENTS, NEW TILES			97	42,500		20	2,125	2,125	39,318	31
32	DOORS, REPLACE TILES, NEW FIXTURES, FAUCETS, TUCKP			97	7,500		20	375	375	6,951	32
33	TUCKPOINTING, PAINTING, REPAIR WALLS, SKYLIGHT			98	43,807		20	2,190	2,190	38,325	33
34	BUILD SCREENED IN PORCH			98	3,295		20	165	165	2,887	34
35	FIRE DOORS, TILING, LIGHT FIXTURES, PAINTING			98	18,600		20	930	930	16,275	35
36	ALUMINUM GUTTERS & DOWNSPOUTS			99	4,350		20	217	217	3,581	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

Facility Name &amp; ID Number BELMONT NURSING HOME

# 0024968

Report Period Beginning:

07/01/2014

Ending:

06/30/2015

**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	PIPED & WIRED A/C RECEPTACLE A/C	2000	\$ 7,045	\$	20	\$ 352	\$ 352	\$ 5,456	37
38	INSTALL WOOD DOOR, LIGHT FIXTURES, PAINTING	2000	4,825		20	241	241	3,736	38
39	PAINTING, LIGHT FIXTURES, TILE FLOORS	2000	4,100		20	205	205	3,178	39
40	FIRE SYSTEM	2000	1,645		20	82	82	1,271	40
41	REPLACE SIDEWALKS AND STAIRS	2000	3,100		20	155	155	2,403	41
42	SUPPLY & INSTALL 4 BATHROOM SINKS, FAUCETS, PLUM	2000	2,650		20	133	133	2,061	42
43	CUSTOM COUNTERS FOR NURSING STATION	2000	2,625		20	131	131	2,031	43
44	CUSTOM BUILD & INSTALL CABINETS IN MED ROOM	2000	3,750		20	188	188	2,914	44
45	FIRE SPRINKLER SYSTEM	2001	7,272		20	364	364	5,278	45
46	23 EXIT SIGNS	2001	4,108		20	205	205	2,973	46
47	FIRE PROTECTION SYSTEM	2001	4,959		20	248	248	3,596	47
48	FIRE ALARM	2002	935		20	47	47	634	48
49	PIPED & WIRED A/C RECEPTACLE A/C	2003	4,759		20	238	238	2,975	49
50	TILING	2004	16,415		20	821	821	9,441	50
51	FENCE	2004	3,276		20	164	164	1,886	51
52	ELECTRICAL WORK	2005	2,500		20	125	125	1,313	52
53	TILING	2005	1,500		20	75	75	788	53
54	SPRINKLER HEADS FOR FIRE PROTECTION	2006	4,450		20	223	223	2,118	54
55	FIRE ESCAPE REPAIR	2006	3,150		20	158	158	1,501	55
56	WINDOW TREATMENTS	2006	721		20	36	36	342	56
57	NEW FIRE ALARM SYSTEM	2007	62,645		20	3,132	3,132	26,622	57
58	TUCKPOINTING BUILDING	2007	8,850		20	442	442	3,757	58
59	NEW SIDEWALKS	2007	5,828		20	292	292	2,482	59
60	REPAIR ROOF, SKYLIGHT & DOWNSPROUTS	2007	5,450		20	272	272	2,312	60
61	REPAIR FENCE, GATES AND STAIR RAILINGS	2007	4,050		20	202	202	1,717	61
62	DRAW NEW FIRE ALARM SYSTEM	2007	5,260		20	264	264	2,244	62
63	NEW DOOR AND LOCK IN KITCHEN	2007	1,652		20	82	82	697	63
64	NEW HEATING & AIR CONDITIONING SYSTEM	2008	9,380		20	469	469	3,518	64
65	NEW ROOF	2008	21,270		20	1,064	1,064	7,980	65
66	FIRE ALARM PROTECTION INSTALLATION	2008	3,844		20	192	192	1,440	66
67	LAMINATE FLOORING	2008	8,085		20	404	404	3,030	67
68	PAINTING ALL ROOMS, HALLWAYS, OFFICES, ETC	2008	40,405		20	2,020	2,020	15,150	68
69	NEW FLOORING	2010	7,161		20	179	179	1,074	69
70	TOTAL (lines 4 thru 69)		\$ 1,054,191	\$		\$ 32,859	\$ 32,859	\$ 891,866	70

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

**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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,054,191	\$		\$ 32,859	\$ 32,859	\$ 891,866	1
2	SPRINKLER HEADS FOR FIRE PROTECTION	2010	3,490		20	175	175	962	2
3	CEMENT WORK IN PATIO	2011	2,925		20	73	73	292	3
4	INSTALL 6' HIGH CINDER BLOCK WALL	2011	2,765		20	69	69	276	4
5	CUBICLE CURTAINS & TRACKS	2011	20,925		20	523	523	2,092	5
6	FENCE	2011	4,373		20	109	109	436	6
7	REDO OPENING INTO KITCHEN (DOOR,FRAME,HDWARE)	2011	5,662		20	142	142	568	7
8	NEW PIPING, MOP BASIN,AND FAUCETS	2011	4,498		20	112	112	448	8
9	NEW ELECTRICAL PIPING FOR NEW WATER HEATER	2011	3,821		20	96	96	384	9
10	west wing first floor shower room rehab-flooring, plumbing,concre	2011	32,680		20	817	817	3,268	10
11	EXTERIOR STEEL STAIRWAY	2011	20,173		20	504	504	2,016	11
12	CIRCUITS FOR A/C UNITS	2011	9,765		20	244	244	976	12
13	repair wire lath painted plaster ceiling in west wing basement	2011	6,852		20	171	171	684	13
14	REDO OPENING INTO CONF ROOM (DOOR,FRAME,HDWE)	2011	4,800		20	120	120	480	14
15	SPRINKLER HEADS	2011	5,900		20	148	148	592	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	TOTAL (lines 1 thru 33)		\$ 1,182,820	\$		\$ 36,162	\$ 36,162	\$ 905,340	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	\$ 122,283	\$ 22,292	\$ 12,197	\$ (10,095)	10 YRS	\$ 54,074	71
72	Current Year Purchases	642		32	32	10 YRS	32	72
73	Fully Depreciated Assets	299,874					299,874	73
74								74
75	TOTALS	\$ 422,799	\$ 22,292	\$ 12,229	\$ (10,063)		\$ 353,980	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 1,605,619	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 22,292	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 48,391	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 26,099	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,259,320	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: **GENEVA INC CO**

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:	1999	61		\$ 277,093	10		3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>		61		\$ 277,093			7

10. Effective dates of current rental agreement:

Beginning 6/01/06

Ending 5/31/16

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

Fiscal Year Ending Annual Rent

12. 2016 \$ 228,948

13. 2017 \$ 228,949

14. 2018 \$ 228,949

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 30,000  
by the length of the lease 10 . 300,000

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

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

15. Is Movable equipment rental included in building rental?

YES  NO

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

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

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

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

**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>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		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	Units	Cost	Units	Cost	Units	Cost	Units	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	<b>TOTAL</b>			\$		\$		\$								14

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

Facility Name & ID Number **BELMONT NURSING HOME**

# **0024968**

Report Period Beginning: **07/01/2014**

Ending: **06/30/2015**

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

As of **06/30/2015** (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 23,055	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	535,674		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	34,362		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <b>Real Estate Escrow Dep.</b>	2,698		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 595,789	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	138,750		14
15	Leasehold Improvements, at Historical Cost	1,044,071		15
16	Equipment, at Historical Cost	422,799		16
17	Accumulated Depreciation (book methods)	(316,411)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <b>RENT SECURITY DEPOSIT</b>	84,500		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,373,709	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,969,498	\$	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 148,106	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	57,998		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 206,104	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	514,380		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 514,380	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 720,484	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,249,014	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,969,498	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ 1,275,178	1
2	Restatements (describe):		2
3	<b>ROUNDING</b>	1	3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ 1,275,179	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(26,165)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (26,165)	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 1,249,014	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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,121,998	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,121,998	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	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		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>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	4	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 4	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,122,002	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	495,202	31
32	Health Care	673,658	32
33	General Administration	611,860	33
<b>B. Capital Expense</b>			
34	Ownership	367,447	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,148,167	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(26,165)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (26,165)	43

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 637,339	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <b>MANAGED CARE INS COMP</b>	965,013	47
48	Other-(specify) <b>PERSONAL PORTION</b>	519,646	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 2,121,998	49

**\*\*TAX RETURN IS PREPARED ON CASI BASIS**

\* 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.

Facility Name & ID Number **BELMONT NURSING HOME**

# **0024968**

Report Period Beginning: **07/01/2014**

Ending: **06/30/2015**

**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	716	716	\$ 28,595	\$ 39.94	1
2	Assistant Director of Nursing	1,924	2,103	63,098	30.00	2
3	Registered Nurses					3
4	Licensed Practical Nurses	8,780	9,012	226,684	25.15	4
5	CNAs & Orderlies	11,205	11,485	109,224	9.51	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,808	1,924	22,126	11.50	9
10	Activity Assistants					10
11	Social Service Workers	2,039	2,079	19,751	9.50	11
12	Dietician					12
13	Food Service Supervisor	1,539	1,827	38,367	21.00	13
14	Head Cook	4,469	4,549	49,605	10.90	14
15	Cook Helpers/Assistants					15
16	Dishwashers	3,879	4,071	44,535	10.94	16
17	Maintenance Workers	1,891	2,091	47,574	22.75	17
18	Housekeepers	5,172	5,468	60,983	11.15	18
19	Laundry					19
20	Administrator	1,196	1,364	65,005	47.66	20
21	Assistant Administrator	1,920	2,080	34,320	16.50	21
22	Other Administrative	1,960	2,080	111,000	53.37	22
23	Office Manager					23
24	Clerical	1,960	2,080	46,800	22.50	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	4,676	4,868	111,178	22.84	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	55,134	57,797	\$ 1,078,845 *	\$ 18.67	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	48	\$ 2,736	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	606	3,636	10-3	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				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	654	\$ 6,372		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,120	\$ 38,000	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	38	345	10-3	52
53	TOTAL (lines 50 - 52)	1,158	\$ 38,345		53

Facility Name & ID Number **BELMONT NURSING HOME**

# **0024968**

Report Period Beginning: **07/01/2014**

Ending: **06/30/2015**

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function				Description	Amount	Description	Amount	
DONNA T. HARRIS	ADMINISTRATOR		\$ 65,005	Workers' Compensation Insurance	\$ 15,733	IDPH License Fee	\$		
MILDRED SHEPPARD	ASST. ADMIN		34,320	Unemployment Compensation Insurance	7,214	Advertising: Employee Recruitment		1,257	
EILEEN CONWAY	OTHER ADMIN	100	111,000	FICA Taxes	81,320	Health Care Worker Background Check			
				Employee Health Insurance	81,568	(Indicate # of checks performed _____)			
				Employee Meals	4,599	Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC		5,710	
				EMPLOYEE 401K	24,741	LICENSES/DUES/SUBSCRIPTIONS		12,886	
				EMPLOYEE BENEFIT - OTHER	988	TRUST/FRANCHISE/CONTRIB/ETC		(5,710)	
				PENSION/PROFIT SHARING PLANS	2,898	Less: Public Relations Expense	(		
						Non-allowable advertising	(		
						Yellow page advertising	(		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 210,325	TOTAL (agree to Schedule V, line 22, col.8)		\$ 219,061	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 14,143
B. Administrative - Other			Amount	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			\$	Description	Line #	Amount	Description	Amount	
							Out-of-State Travel	\$	
							In-State Travel		
							Seminar Expense		
							Entertainment Expense	(	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$
C. Professional Services			Amount						
Vendor/Payee	Type		\$						
COMCAST CABLE	DATA PROCESSING		839						
KRUPNICK BOKOR	ACCOUNTING		4,000						
ACHILLE BENKO & DUVAL	ACCOUNTING		8,871						
PIERCE RIESBECK	ACCOUNTING		520						
KEVIN CONWAY	LEGAL		625						
SCHMIDT SALZMAN	LEGAL		2,643						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 17,498						

\* 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												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name &amp; ID Number BELMONT NURSING HOME

# 0024968

Report Period Beginning: 07/01/2014

Ending: 06/30/2015

## 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. ALLIANCE FOR LIVING \$7,908
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (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? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 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. \_\_\_\_\_
- (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. \$ \_\_\_\_\_  
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. \$ 4,599 Has any meal income been offset against related costs? N/A 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? 5%  
d. Have vehicle usage logs been maintained? NO  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES  
**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? NO  
Firm Name: \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. YES  
Attach invoices and a summary of services for all architect and appraisal fees.