FOR BHF USE

LL1

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

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0004499

Facility Name: Bel-Wood Nursing Home

Address: 6701 West Plank Road (Number) Peoria (City) 61604 (Zip Code)

County: Peoria

Telephone Number: (309) 697-4541 **Fax #** (309) 697-6622

HFS ID Number:

Date of Initial License for Current Owners: 11/30/1968

Type of Ownership:

[ ] VOLUNTARY,NON-PROFIT		[ ] PROPRIETARY		[X] GOVERNMENTAL	
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[X]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Michael W. Martin **Telephone Number:** (217) 258-8888
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/10 to 12/31/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title)
(Firm Name & Address) McGladrey & Pullen, LLP, 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bel-Wood Nursing Home # 0004499 Report Period Beginning: 01/01/10 Ending: 12/31/10

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	300	Skilled (SNF)	300	109,500	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	300	TOTALS	300	109,500	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	9,076	385	7,068	16,529	8
9	SNF/PED					9
10	ICF	52,991	13,599		66,590	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	62,067	13,984	7,068	83,119	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.91%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/30/1968

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 50 and days of care provided 7,068

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/10 Fiscal Year: 12/31/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bel-Wood Nursing Home # 0004499 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	687,812	33,430		721,242		721,242		721,242			1
2	Food Purchase		453,781		453,781		453,781	(7,338)	446,443			2
3	Housekeeping	404,082	46,613	20,161	470,856		470,856		470,856			3
4	Laundry	167,230	34,345		201,575		201,575	(4,194)	197,381			4
5	Heat and Other Utilities			379,591	379,591		379,591		379,591			5
6	Maintenance	109,021	26,842	94,227	230,090		230,090	6,299	236,389			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,368,145	595,011	493,979	2,457,135		2,457,135	(5,233)	2,451,902			8
	B. Health Care and Programs											
9	Medical Director			5,000	5,000		5,000		5,000			9
10	Nursing and Medical Records	5,378,032	539,655	624,765	6,542,452		6,542,452		6,542,452			10
10a	Therapy		2,653	728,469	731,122		731,122		731,122			10a
11	Activities	283,020	7,730	1,622	292,372		292,372	(413)	291,959			11
12	Social Services	120,702		1,402	122,104		122,104		122,104			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	5,781,754	550,038	1,361,258	7,693,050		7,693,050	(413)	7,692,637			16
	C. General Administration											
17	Administrative	114,232		189,720	303,952		303,952	2,350	306,302			17
18	Directors Fees							61,559	61,559			18
19	Professional Services			172,775	172,775		172,775	119,316	292,091			19
20	Dues, Fees, Subscriptions & Promotions			22,567	22,567		22,567		22,567			20
21	Clerical & General Office Expenses	356,729	3,186	50,601	410,516		410,516	119,779	530,295			21
22	Employee Benefits & Payroll Taxes			628,418	628,418		628,418	748,407	1,376,825			22
23	Inservice Training & Education			8,288	8,288		8,288		8,288			23
24	Travel and Seminar			9,337	9,337		9,337		9,337			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			228,611	228,611		228,611	(117,865)	110,746			26
27	Other (specify):*											27
28	**TOTAL General Administration**	470,961	3,186	1,310,317	1,784,464		1,784,464	933,546	2,718,010			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	7,620,860	1,148,235	3,165,554	11,934,649		11,934,649	927,900	12,862,549			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Bel-Wood Nursing Home #0004499 Report Period Beginning: 01/01/10 Ending: 12/31/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			437,629	437,629		437,629	(29,567)	408,062			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			34,462	34,462		34,462		34,462			35
36	Other (specify):*											36
37	**TOTAL Ownership**			472,091	472,091		472,091	(29,567)	442,524			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		184,536	48,449	232,985		232,985	(48,449)	184,536			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			164,250	164,250		164,250		164,250			42
43	Other (specify):* Non-Allowable Cos			62,238	62,238		62,238	(62,238)				43
44	**TOTAL Special Cost Centers**		184,536	274,937	459,473		459,473	(110,687)	348,786			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	7,620,860	1,332,771	3,912,582	12,866,213		12,866,213	787,646	13,653,859			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bel-Wood Nursing Home # 0004499 Report Period Beginning: 01/01/10 Ending: 12/31/10

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(29,567)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	140	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(34,404)	43		24
25	Fund Raising, Advertising and Promotional	(33,970)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(70,764)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (168,565)		$	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 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	956,211		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 956,211		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 787,646		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44						44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Bel-Wood Nursing Home

ID# 0004499

Report Period Beginning: 01/01/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset meal revenue	$ (7,338)	2	1
2	Offset non-resident laundry revenue	(4,194)	4	2
3	Loss on disposition of assets	(139)	43	3
4	Disallow Medicare Ancillary Costs	(48,449)	39	4
5	Employee Recognitions & Awards	(1,371)	22	5
6	Accrued Compensated Absence Audit Expense	6,135	43	6
7	Disallow Cable TV	(14,375)	21	7
8	Disallow Phone	(620)	21	8
9	Non-allowable pet donations	(413)	11	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**	(70,764)		49

Facility Name & ID Number Bel-Wood Nursing Home # 0004499 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Peoria County	100			N/A		

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. [X] 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 Item	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)	
1	V	6	Facility Management	$	Peoria County	100.00%	$ 6,299	$ 6,299	1
2	V	17	Management Fee	189,720	Peoria County	100.00%	192,070	2,350	2
3	V	18	County Board		Peoria County	100.00%	61,559	61,559	3
4	V	19	Professional Services	144,768	Peoria County	100.00%	264,084	119,316	4
5	V	21	Clerical Services		Peoria County	100.00%	134,774	134,774	5
6	V	22	Employee Benefits-Health	627,049	Peoria County	100.00%	432,413	(194,636)	6
7	V	22	IMRF		Peoria County	100.00%	241,477	241,477	7
8	V	22	FICA		Peoria County	100.00%	534,532	534,532	8
9	V	22	EmployeeBenefits-WorkComp	198,165	Peoria County	100.00%	117,744	(80,421)	9
10	V	22	Employee Benefits - U/C	10,455	Peoria County	100.00%	50,661	40,206	10
11	V	26	Liability Insurance	19,656	Peoria County	100.00%	110,411	90,755	11
12	V								12
13	V								13
14	Total			$ 1,189,813			$ 2,146,024	$ * 956,211	14

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

Facility Name & ID Number Bel-Wood Nursing Home # 0004499 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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 Item	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)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bel-Wood Nursing Home # 0004499 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Lynn Scott Pearson	Chairperson	Administrative	0.00	N/A	2	0.05	N/A	$ N/A	N/A	1
2	Bonnie J. Hester	Vice-Chairperson	Administrative	0.00	N/A	1	0.03	N/A	N/A	N/A	2
3	Brian Elsasser	Member	Administrative	0.00	N/A	1	0.03	N/A	N/A	N/A	3
4	Matthew Bartolo	Member	Administrative	0.00	N/A	1	0.03	N/A	N/A	N/A	4
5	Phillip Salzer	Member	Administrative	0.00	N/A	1	0.03	N/A	N/A	N/A	5
6	Merle Widmer	Member	Administrative	0.00	N/A	1	0.03	N/A	N/A	N/A	6
7											7
8											8
9											9
10	Andrew Rand, a member of the Peoria County Board, is CEO of Advanced Medical Transport of Central Illinois which furnished medical transportation for Bel-Wood.										10
11	Mr. Rand is not a member of the Health & Environmental Svcs. Committee which directly oversees Bel-Wood Nursing Home.										11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Bel-Wood Nursing Home # 0004499 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Facility Management	Direct allocation per			$	$		$ 6,299	1
2	18	County Board	Maximus, Inc. Please						61,559	2
3	19	Professional Services	see attached schedule.						264,084	3
4	21	Clerical Services	Further detail						134,774	4
5	22	Employee Benefits-Health	available upon						432,413	5
6	22	Employee Benefits-Work Comp	request.						110,411	6
7	22	Employee Benefits-U/C							117,744	7
8	26	Liability Insurance							50,661	8
9										9
10	17	Management Fee	Direct Cost						192,070	10
11	22	IMRF	Direct Cost						241,477	11
12	22	FICA	Direct Cost						534,532	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 2,146,024	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bel-Wood Nursing Home # 0004499 Report Period Beginning: 01/01/10 Ending: 12/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6							N/A					6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Bel-Wood Nursing Home **#** 0004499 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	**2009**	$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(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.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005		8
	2006		9
	2007		10
	2008		11
	2009	N/A	12

County facility-pays no real estate tax.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Bel-Wood Nursing Home COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0004499

CONTACT PERSON REGARDING THIS REPORT Joyce Harmon

TELEPHONE (309) 677-6233 FAX #: N/A

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

Enter the tax index number and real estate tax assessed for 2009 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 2009.

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number Bel-Wood Nursing Home # 0004499 Report Period Beginning: 01/01/10 Ending: 12/31/10

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	348,480	1848	$ 100	1
2					2
3	TOTALS	348,480		$ 100	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bel-Wood Nursing Home # 0004499 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	300		1969	1969	$ 3,123,273	$ 62,471	50	$ 62,471	$	$ 2,623,566	4
5			1975	1975	4,223	92	45	92		3,373	5
6			1986	1986	47,151		Various			47,151	6
7											7
8											8
	Improvement Type**										
9	Improvements			1978	10,851	271	40	271		8,970	9
10	Improvements			1979	23,127		20-25			23,127	10
11	Improvements			1980	115,619		20-25			115,619	11
12	Improvements			1984	15,544		Various			15,544	12
13	Improvements			1985	511,366		Various			511,366	13
14	Improvements			1986	45,660		20			45,660	14
15	Improvements			1987	936		Various			936	15
16	Improvements			1988	104,423		Various			104,423	16
17	Improvements			1989	158,141		Various			158,141	17
18	Improvements			1990	140,837		Various			140,837	18
19	Improvements			1991	599,124	29,956	Various	29,956		502,767	19
20	Improvements			1992	188,119	8,461	Various	8,461		188,119	20
21	Improvements			1995	4,885	244	16-20	244		3,719	21
22	Building Improvements (2009 - disposal of 8774)			1995	14,869		5-20			14,869	22
23	Resurface Driveway			1996	2,947	184	16	184		2,484	23
24	Telephone Wiring			1996	2,383	119	20	119		1,587	24
25	Faucets			1997	1,862	93	20	93		1,217	25
26	Replace Floor			1997	1,035	52	20	52		680	26
27	Remodeling			1997	1,291	65	20	65		877	27
28	Door Replacement			1997	4,957	248	20	248		3,431	28
29	Ceiling tile			1997	1,488	99	15	99		1,361	29
30	Concrete Slabs			1997	825	41	20	41		557	30
31	Sinks			1997	3,718	186	20	186		2,495	31
32	Plumbing			1997	2,397	96	25	96		1,288	32
33	Compressor (disposed of in 2009)			1997							33
34	Fireplace			1998	946	47	20	47		588	34
35	Bi-fold Doors			1998	27,343		10			27,343	35
36	Sink System			1998	2,569	128	20	128		1,622	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

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

Facility Name & ID Number Bel-Wood Nursing Home # 0004499 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Handrails	1998	$ 1,955	$	10	$	$	$ 1,955	37
38	Water Softener	1998	34,106	1,897	12	1,897		34,106	38
39	Roof Repair	1998	3,760		10			3,760	39
40	Wallpaper	1998	985	49	20	49		617	40
41	Wallpaper	1998	1,885	94	20	94		1,191	41
42	Wallpaper	1998	1,075	54	20	54		688	42
43	Wallpaper	1998	434	22	20	22		271	43
44	Roof Repair	1998	3,467		10			3,467	44
45	Undergoround Storage Tank	1998	26,041	651	40	651		8,463	45
46	Energy Management System Modifications	1999	3,732		10			3,732	46
47	Roof Repairs	2000	1,254	84	15	84		966	47
48	Architect fees per IDPA review of 1999 cost report	2000	15,290	1,911	8	1,911		15,288	48
49	Shelving, dish room	2000	1,500	75	20	75		806	49
50	Door relocation	2000	1,461	73	20	73		779	50
51	Roof Repairs	2000	3,552	237	15	237		2,508	51
52	Water Main #1	2000	3,178	127	25	127		1,334	52
53	Sidewalk Replacement	2000	1,350	68	20	68		714	53
54	Water Main #2	2000	2,120	85	25	85		878	54
55	Door guards	2000	1,694	85	20	85		871	55
56	Door, magnetic lock	2000	4,062	203	20	203		2,064	56
57	Replacement glass	2001	2,971	149	20	149		1,477	57
58	Fire System	2001	496		8			496	58
59	Water heater replacement	2001	84,666		8			84,666	59
60	Drawer front machine	2001	1,690	113	15	113		1,102	60
61	Windows	2002	59,439	2,972	20	2,972		24,519	61
62	Resident Alarm System	2002	43,538	2,177	20	2,177		17,597	62
63	Exit Device	2002	1,862	186	10	186		1,488	63
64	Egress Bars for Doors	2002	2,630	263	10	263		2,126	64
65	Rooftop Unit Pilot Program Phase 1	2002	1,420	95	15	95		760	65
66	Construction Documents	2002	6,750	844	8	844		6,752	66
67	Control Wiring	2002	2,495	125	20	125		1,073	67
68	Roof Repairs	2002	1,642	109	15	109		954	68
69	Exit Signs	2003	2,596	260	10	260		2,058	69
70	TOTAL (lines 4 thru 69)		$ 5,487,005	$ 115,859		$ 115,859	$	$ 4,783,241	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Bel-Wood Nursing Home # 0004499 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,487,005	$ 115,859		$ 115,859	$	$ 4,783,241	1
2	Air Cylinder - Drain	2003	1,049	105	10	105		805	2
3	Zone Motor & Bases	2003	4,211	421	10	421		3,087	3
4	Construction Documentation	2003	12,854	1,607	8	1,607		11,651	4
5	Fence for Alzheimer Unit	2003	4,277	285	15	285		2,066	5
6	Parking lot overlay	2003	39,414	2,463	16	2,463		17,858	6
7	Water heater replacement	2003	52,500	3,500	15	3,500		25,375	7
8	Engineering	2003	3,700	463	8	463		3,317	8
9	Water main replacement	2003	80,810	3,232	25	3,232		22,894	9
10	Fire alarm panel replacement	2003	22,710	1,136	20	1,136		8,046	10
11	Reception Area Remodel	2003	2,904	145	20	145		1,015	11
12	Double Egress Doors	2004	2,585	259	10	259		1,682	12
13	Alzheimer Security	2004	26,381		5			26,381	13
14	Wallpaper HC & Norwood	2004	3,237		5			3,237	14
15	Blinds HC & Glasford	2004	6,070		5			6,070	15
16	Fire Alarm system	2004	111,652	11,165	10	11,165		70,712	16
17	Aluminum Awning (disposed of in 2009)	2004			10				17
18	Roof Repairs	2004	3,383	338	10	338		2,057	18
19	Fire alarm wiring	2004	5,812	581	10	581		3,486	19
20	Electrical service	2004	3,132	313	10	313		1,904	20
21	Compressor repairs	2004	10,589		5			10,590	21
22	Reception area shades	2004	2,062		5			2,062	22
23	Addition to watermain	2004	30,505	1,271	24	1,271		8,579	23
24	Door closer and locks	2004	2,366	237	10	237		1,598	24
25	Water heater replacement	2005	1,204	144	5	144		1,204	25
26	Roof Repairs - Massey	2005	15,793	1,579	10	1,579		8,027	26
27	Engine Control Panel	2005	35,025	1,751	20	1,751		9,923	27
28	Door closer and locks	2005	899	90	10	90		457	28
29	Carpeting	2005	1,735	87	5	87		1,735	29
30	Sink Repairs	2005	5,514	734	5	734		5,514	30
31	AA D379 Engine Repair	2005	1,300		5			1,300	31
32	Front Door Repair	2005	1,235	82	5	82		1,235	32
33	Carpeting	2005	1,563	181	5	181		1,563	33
34	TOTAL (lines 1 thru 33)		$ 5,983,476	$ 148,028		$ 148,028	$	$ 5,048,671	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Bel-Wood Nursing Home # 0004499 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 5,983,476	$ 148,028		$ 148,028	$	$ 5,048,671	1
2	C-wing Faux Wood Blinds	2005	4,998	498	5	498		4,998	2
3	Water Softener Overhaul	2005	1,574	157	5	157		1,574	3
4	Smoke Detector	2005	1,710	171	10	171		1,012	4
5	4 Plexiglass Flower Boxes	2005	1,580	26	5	26		1,580	5
6	Domestic Hot Water Temp Valve	2005	2,082	36	5	36		2,082	6
7	Carpeting	2005	7,333	487	5	487		7,333	7
8	HVAC Repairs	2005	103,550	10,355	5	10,355		103,550	8
9	Booster Pump	2006	4,000	800	5	800		3,267	9
10	Doors and Locks	2006	8,760	1,752	5	1,752		7,154	10
11	Door Latch Replacement	2006	28,360	5,672	5	5,672		27,415	11
12	Roof Repairs	2006	19,515		3			19,515	12
13	HVAC Repairs	2006	52,475		3			52,475	13
14	Victory chiller swing door	2007	9,573	957	10	957		2,871	14
15	HVAC repairs	2007	44,128	14,709	3	14,709		44,127	15
16	Roof repairs	2007	9,240	3,080	3	3,080		9,240	16
17	Electrical upgrade	2007	42,840	4,284	10	4,284		12,852	17
18	Boiler pump	2007	3,274	655	5	655		1,965	18
19	Smoke dampers	2007	31,696	3,170	10	3,170		9,510	19
20	Fire Alarm	2007	6,770	677	10	677		2,537	20
21	Water back flows	2007	3,977	795	5	795		2,982	21
22	Outdoor walk-in freezer	2007	22,300	2,230	10	2,230		8,363	22
23	Carpeting	2007	3,172	634	5	634		2,325	23
24	Draper shades for hallway	2007	9,820	1,964	5	1,964		6,874	24
25	Disposal (disposed of in 2009	2007							25
26	Front Door Patient Alarm	2007	2,580	516	5	516		1,763	26
27	Firewall for IDPH	2007	3,450	690	5	690		2,243	27
28	Booster Pump	2007	47,390	9,478	5	9,478		30,014	28
29	Ceiling Tile Replacement	2007	15,493	3,099	5	3,099		9,813	29
30	Sidewalks	2007	4,060	406	10	406		1,421	30
31	Main Enterance Delayed Exit A	2008	3,415	1,138	3	1,138		2,655	31
32	HVAC Repairs	2008	64,942	21,647	3	21,647		43,294	32
33	Roof Repairs	2008	8,308	2,769	3	2,769		5,538	33
34	TOTAL (lines 1 thru 33)		$ 6,555,841	$ 240,880		$ 240,880	$	$ 5,481,013	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Bel-Wood Nursing Home # 0004499 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 6,555,841	$ 240,880		$ 240,880	$	$ 5,481,013	1
2	Boiler Replacement	2008	18,200	6,067	3	6,067	0	17,190	2
3	Hot Water Heater Repairs	2008	3,606	1,202	3	1,202		2,905	3
4	Faux Wood Blinds	2008	22,596	7,532	3	7,532		15,064	4
5									5
6	HVAC Repairs	2009	76,683	38,342	2	38,342		38,342	6
7	Roof Repairs	2009	14,328	7,164	2	7,164		7,164	7
8	Flooring - First Floor	2009	4,657	2,329	2	2,329		3,299	8
9									9
10	Hammerall Disposer 3HP	2010	7,430	3,096	2	3,096		3,096	10
11	HVAC Repairs	2010	45,296		2				11
12	Roof Repairs	2010	8,789		2				12
13	Fusible Link/Booster heater	2010	6,539	2,915	2	2,915		2,915	13
14	Emergency Pump Repair	2010	3,154	657	2	657		657	14
15	Fauxwood Blinds	2010	2,773	347	2	347		347	15
16	Sidewalk Repair	2010	2,675	892	2	892		892	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31	Adjust to financial statement information			29,567			(29,567)	74,863	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,772,567	$ 340,990		$ 311,423	$ (29,567)	$ 5,647,747	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Bel-Wood Nursing Home # 0004499 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 499,887	$ 61,784	$ 61,784	$	5	$ 327,402	71
72	Current Year Purchases	66,225	4,818	4,818		5	4,818	72
73	Fully Depreciated Assets	505,206	30,037	30,037		5	505,205	73
74								74
75	TOTALS	$ 1,071,318	$ 96,639	$ 96,639	$		$ 837,425	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Maintenance	2010 Dodge Ram Truck	2000	$ 13,998	$	$	$	8	$ 13,998	76
77	Resident Transportation	1997 Ford El Dorado	1997	42,701				4	42,701	77
78										78
79										79
80	TOTALS			$ 56,699	$	$	$		$ 56,699	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 7,900,684	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 437,629	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 408,062	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (29,567)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,541,871	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	NA				87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93	NA		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.

Facility Name & ID Number Bel-Wood Nursing Home # 0004499 Report Period Beginning: 01/01/10 Ending: 12/31/10

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				N/A			4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

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.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ 34,462 Description: Medical Equipment - 27,088; Duplicating Equipment - 7,374
(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			N/A		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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bel-Wood Nursing Home # 0004499 Report Period Beginning: 01/01/10 Ending: 12/31/10

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bel-Wood Nursing Home # 0004499 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(2),(3)	hrs	$	5,162	$ 302,532	$ 2,653	5,162	$ 305,185	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,339	121,037		2,339	121,037	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		6,169	304,900		6,169	304,900	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				184,536		184,536	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			$	13,670	$ 728,469	$ 187,189	13,670	$ 915,658	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Bel-Wood Nursing Home # 0004499 Report Period Beginning: 01/01/10 Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 4,225,722	$ 4,225,722	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 311,000)	2,774,697	2,774,697	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	3,000,000	3,000,000	5
6	Prepaid Insurance	153,650	153,650	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 10,154,069	$ 10,154,069	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	100	100	13
14	Buildings, at Historical Cost	6,274,223	3,174,647	14
15	Leasehold Improvements, at Historical Cost	168,322	3,597,920	15
16	Equipment, at Historical Cost	1,128,017	1,128,017	16
17	Accumulated Depreciation (book methods)	(6,196,444)	(6,541,871)	17
18	Deferred Charges	5,815	5,815	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe CIP	2,495,361	2,495,361	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,875,394	$ 3,859,989	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 14,029,463	$ 14,014,058	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 546,860	$ 546,860	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	126,727	126,727	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	415,081	415,081	36
37	Due to the State of Illinois	1,382,191	1,382,191	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,470,859	$ 2,470,859	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			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)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,470,859	$ 2,470,859	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 11,558,604	$ 11,543,199	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 14,029,463	$ 14,014,058	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Bel-Wood Nursing Home
Provider ID#: 0004499
FYE 12/31/10

Supplementary Information

Schedule 17A

XV. BALANCE SHEET - Line 36 - Other Current Liabilities

	Operating	After Consolidation
Accrued Vacation & Comp Time	281,216	281,216
Deferred Revenue	133,800	133,800
Miscellaneous Due to Others	65	65
Total P17 L 36	415,081	415,081

See Accountants' Compliation Report

Facility Name & ID Number Bel-Wood Nursing Home # 0004499 Report Period Beginning: 01/01/10 Ending: 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 8,332,407	1
2	Restatements (describe):		2
3			3
4	**Prior Period Adjustment**	(6,931)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 8,325,476	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	3,233,128	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	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 3,233,128	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)**	$ 11,558,604	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bel-Wood Nursing Home # 0004499 Report Period Beginning: 01/01/10 Ending: 12/31/10

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 15,487,416	1
2	Discounts and Allowances for all Levels	(2,932,007)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 12,555,409	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,112,829	6
7	Oxygen	80,165	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,192,994	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	203,967	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)**	$ 203,967	23
	D. Non-Operating Revenue		
24	Contributions	5,537	24
25	Interest and Other Investment Income***	46,642	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 52,179	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	See Schedule 19A	2,094,792	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,094,792	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 16,099,341	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,457,135	31
32	Health Care	7,693,050	32
33	General Administration	1,784,464	33
	B. Capital Expense		
34	Ownership	472,091	34
	C. Ancillary Expense		
35	Special Cost Centers	295,223	35
36	Provider Participation Fee	164,250	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,866,213	40
41	**Income before Income Taxes (line 30 minus line 40)****	3,233,128	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 3,233,128	43

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

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

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

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

Bel-Wood Nursing Home
Provider ID#: 0004499
FYE 12/31/10

Supplementary Information

Schedule 19A

XVII. INCOME STATEMENT - Line 28a - Other Revenue

	Amount
Miscellaneous Fee for Services	11,945
Property Tax	1,916,856
Vending Machines	9,446
Recovery of Bad Debts	156,104
Copies	196
Miscellaneous unanticipated	245
Total P19 L 28a	2,094,792

See Accountants' Compliation Report

Facility Name & ID Number Bel-Wood Nursing Home # 0004499 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,866	2,088	$ 88,086	$ 42.19	1
2	Assistant Director of Nursing	3,784	4,509	124,489	27.61	2
3	Registered Nurses	11,940	14,731	336,225	22.82	3
4	Licensed Practical Nurses	64,069	81,100	1,557,815	19.21	4
5	CNAs & Orderlies	199,215	224,664	3,145,669	14.00	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,869	2,115	49,291	23.31	9
10	Activity Assistants	8,122	10,160	233,729	23.00	10
11	Social Service Workers	3,441	4,215	120,702	28.64	11
12	Dietician					12
13	Food Service Supervisor	1,820	2,081	59,617	28.65	13
14	Head Cook	2,498	4,328	57,233	13.22	14
15	Cook Helpers/Assistants	39,365	49,669	570,962	11.50	15
16	Dishwashers					16
17	Maintenance Workers	5,573	6,466	109,021	16.86	17
18	Housekeepers	28,123	32,444	404,082	12.45	18
19	Laundry	12,730	14,755	167,230	11.33	19
20	Administrator	1,830	2,080	114,232	54.92	20
21	Assistant Administrator					21
22	Other Administrative	5,385	6,177	101,982	16.51	22
23	Office Manager					23
24	Clerical	17,267	19,888	254,747	12.81	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,493	4,228	76,717	18.14	31
32	Other Health Care(specify)					32
33	Other(specify) Care Plan Corrdir	1,884	2,194	49,031	22.35	33
34	TOTAL (lines 1 - 33)	414,274	487,892	$ 7,620,860 *	$ 15.62	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	5,000	9(3)	36
37	Medical Records Consultant	Monthly	1,840	10(3)	37
38	Nurse Consultant	Monthly	8,158	10(3)	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	1,622	11(3)	44
45	Social Service Consultant	Monthly	1,402	12(3)	45
46	Other(specify)				46
47	Management Consultant	Monthly	1,030	21(3)	47
48					48
49	TOTAL (lines 35 - 48)		$ 19,052		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,927	$ 68,528	10(3)	50
51	Licensed Practical Nurses	14,306	421,481	10(3)	51
52	Certified Nurse Assistants/Aides	7,753	124,758	10(3)	52
53	TOTAL (lines 50 - 52)	23,986	$ 614,767		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Bel-Wood Nursing Home # 0004499 Report Period Beginning: 01/01/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Matt Nieukirk	Administrator	0	$ 114,232
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 114,232

B. Administrative - Other

Description	Amount
Peoria County (Management Fee)	$ 189,720
TOTAL (agree to Schedule V, line 17, col. 3)	$ 189,720
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
McGladrey & Pullen LLP	Accounting	$ 12,100
Koch Consultants LLP	Accounting	3,100
Duane Morris LLP	Legal	1,705
E-Health Data Solutions	Data Management	9,102
Curaspan Healthgroup	Data Management	2,000
Peoria County	Data Processing	144,768
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 172,775

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 117,744
Unemployment Compensation Insurance	50,661
FICA Taxes	534,532
Employee Health Insurance	432,411
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	241,477
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,376,825

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 498
Advertising: Employee Recruitment	3,935
Health Care Worker Background Check	
(Indicate # of checks performed 125)	1,147
Patient Background Checks 93	853
Life Services Network of Illinois dues	9,743
AAHSA dues	4,377
Miscellaneous Dues & Subscriptions	1,566
Promotional Advertising	33,970
Miscellaneous Fees	448
Less: Public Relations Expense	( )
Non-allowable advertising	(33,970)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 22,567

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 317
In-State Travel	4,269
Seminar Expense	4,751
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,337

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Bel-Wood Nursing Home
Provider ID#: 0004499
FYE 12/31/10

Supplementary Information

Schedule 21A

XIXI. Support Schedules - Section C - Provessional Services

	Amount
Per Schedule V, L19, C3	172,775
County Allocation	119,316
Per Schedule V, L19, C8	292,091

See Accountants' Compliation Report

Facility Name & ID Number Bel-Wood Nursing Home # 0004499 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3								N/A					
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bel-Wood Nursing Home # 0004499 Report Period Beginning: 01/01/10 Ending: 12/31/10

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **LSNI-$9,743 AAHSA-$4,377**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **3 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **172,460** Line **10(2)**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **164,250**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **7,338**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Baker Tilly**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.