FOR BHF USE

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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: 0024968

Facility Name: BELMONT NURSING HOME

Address: 1936 WEST BELMONT AVENUE (Number) CHICAGO (City) 60657 (Zip Code)

County: COOK

Telephone Number: (773) 525-7176 **Fax #** (773) 525-8929

HFS ID Number:

Date of Initial License for Current Owners: 10/16/79

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585
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 07/01/2009 to 06/30/2010 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) EILEEN CONWAY
(Title) PRESIDENT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANT'S REPORT) (Date)
(Print Name and Title) BOB KAGDA, VICE PRESIDENT
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

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

Facility Name & ID Number BELMONT NURSING HOME # 0024968 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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 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		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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	18,356	98		18,454	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,356	98		18,454	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.88%

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 [X]

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 10/16/79

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/16/79 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided 0

Medicare Intermediary _____

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2010 Fiscal Year: 06/30/2010

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

Facility Name & ID Number BELMONT NURSING HOME # 0024968 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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	121,664	21,443	2,640	145,747		145,747		145,747			1
2	Food Purchase		86,505		86,505	(3,263)	83,242	(734)	82,508			2
3	Housekeeping	51,868	36,145		88,013		88,013		88,013			3
4	Laundry											4
5	Heat and Other Utilities			33,031	33,031		33,031		33,031			5
6	Maintenance	55,626		42,147	97,773		97,773		97,773			6
7	Other (specify):*			10,618	10,618		10,618		10,618			7
8	TOTAL General Services	229,158	144,093	88,436	461,687	(3,263)	458,424	(734)	457,690			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	520,204	11,816	7,546	539,566		539,566		539,566			10
10a	Therapy											10a
11	Activities	25,645	8,075		33,720		33,720		33,720			11
12	Social Services	55,284		2,060	57,344		57,344		57,344			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	601,133	19,891	9,606	630,630		630,630		630,630			16
	C. General Administration											
17	Administrative	242,230			242,230		242,230		242,230			17
18	Directors Fees											18
19	Professional Services			58,668	58,668		58,668		58,668			19
20	Dues, Fees, Subscriptions & Promotions			4,829	4,829		4,829		4,829			20
21	Clerical & General Office Expenses	8,625	30,914	7,596	47,135		47,135	(2,550)	44,585			21
22	Employee Benefits & Payroll Taxes			217,915	217,915	3,263	221,178		221,178			22
23	Inservice Training & Education			188	188		188		188			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			2,600	2,600		2,600		2,600			25
26	Insurance-Prop.Liab.Malpractice			49,678	49,678		49,678		49,678			26
27	Other (specify):*											27
28	TOTAL General Administration	250,855	30,914	341,474	623,243	3,263	626,506	(2,550)	623,956			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,081,146	194,898	439,516	1,715,560		1,715,560	(3,284)	1,712,276			29

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

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

Facility Name & ID#: BELMONT NURSING HOME **#0024968** **Report Period Beginning: 07/01/2009** **Ending: 06/30/2010**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	2,640	
	REPAIRS & MAINTENANCE		0	
			0	2,640
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		16,473	
	ELECTRICITY		10,729	
	WATER		5,829	
	CABLE TV - LOBBY		0	
			0	33,031
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		0	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		36,284	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		0	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		864	
	FIRE SERVICE		4,999	
			0	
			0	
			0	
			0	42,147
7	**OTHER**			
	SCAVENGER		10,618	
	SECURITY SERVICE		0	
			0	
			0	10,618
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	0	0

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	6,077	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	1,469	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	7,546
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS			
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
			0	0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES			
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	2,060	
			0	2,060
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number BELMONT NURSING HOME **#0024968** **Report Period Beginning: 07/01/2009** **Ending: 06/30/2010**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	0	0
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	919	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	57,749	
			0	58,668
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	0	
	EMPLOYEE WANT ADS	XIX F	199	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	4,112	
	LICENSES & PERMITS	XIX F	150	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	368	
	PATIENT BACKGROUND CHECKS	XIX F	0	
				4,829
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		275	
	EQUIPMENT REPAIR & MAINTENANCE		0	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	2,550	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		4,771	
	MESSENGER SERVICE		0	
			0	7,596

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	80,744	
	UNEMPLOYMENT COMPENSATION	XIX D	4,351	
	WORKERS COMPENSATION INSURANC	XIX D	23,054	
	HOSPITALIZATION INSURANCE	XIX D	82,271	
	EMPLOYEE BENEFITS - OTHER	XIX D	23,928	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	3,567	
	CHICAGO HEAD TAX	XIX D	0	
			0	217,915
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		188	
				188
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		2,600	
				2,600
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		49,678	
				49,678
27	**OTHER**			
	BAD DEBTS	VI 24	0	
				0

GRAND TOTAL COLUMN 3 OTHER **439,516**

BELMONT NURSING HOME
SCHEDULES
06/30/2010

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

TOTAL FOOD PURCHASE	86,505
LESS SALES TAX	(734)
NET FOOD	85,771
TOTAL PATIENT CENSUS	18,454
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	55,362
ADD # EMPLOYEE MEALS/DAY	6
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	2,190
PATIENT MEALS	55,362
ADD EMPLOYEE MEALS	2,190
TOTAL MEALS/YEAR	57,552
NET FOOD	85,771
DIVIDE TOTAL MEALS/YEAR	57,552
COST PER MEAL	1.49
TIME EMPLOYEE MEALS	2,190
EMPLOYEE MEAL RECLASSIFICATION	**3,263**
	========

Facility Name & ID Number BELMONT NURSING HOME #0024968 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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			52,552	52,552		52,552		52,552			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			39,090	39,090		39,090	(1,002)	38,088			32
33	Real Estate Taxes			56,537	56,537		56,537		56,537			33
34	Rent-Facility & Grounds			280,723	280,723		280,723		280,723			34
35	Rent-Equipment & Vehicles			750	750		750		750			35
36	Other (specify):* AMORTIZATION			701	701		701		701			36
37	**TOTAL Ownership**			430,353	430,353		430,353	(1,002)	429,351			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			33,398	33,398		33,398		33,398			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			33,398	33,398		33,398		33,398			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,081,146	194,898	903,267	2,179,311		2,179,311	(4,286)	2,175,025			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: 07/01/2009 Ending: 06/30/2010

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		30		9
10	Interest and Other Investment Income	(920)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(734)	2		13
14	Non-Care Related Interest	(82)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(2,550)	21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional		20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (4,286)		$	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)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (4,286)		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					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

BELMONT NURSING HOME

ID# 0024968

Report Period Beginning: 07/01/2009

Ending: 06/30/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 0	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BELMONT NURSING HOME # 0024968 **Report Period Beginning:** 07/01/2009 **Ending:** 06/30/2010

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(734)	0	0	0	0	0	0	0	0	0	0	(734)	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	**TOTAL General Services**	(734)	0	0	0	0	0	0	0	0	0	0	(734)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(2,550)	0	0	0	0	0	0	0	0	0	0	(2,550)	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	**TOTAL General Administration**	(2,550)	0	0	0	0	0	0	0	0	0	0	(2,550)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(3,284)	0	0	0	0	0	0	0	0	0	0	(3,284)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BELMONT NURSING HOME # 0024968 **Report Period Beginning:** 07/01/2009 **Ending:** 06/30/2010

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

	Capital Expense D. Ownership	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)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,002)	0	0	0	0	0	0	0	0	0	0	(1,002)	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	**TOTAL Ownership**	(1,002)	0	0	0	0	0	0	0	0	0	0	(1,002)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(4,286)	0	0	0	0	0	0	0	0	0	0	(4,286)	45

Facility Name & ID Number BELMONT NURSING HOME # 0024968 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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

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)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

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

Facility Name & ID Number BELMONT NURSING HOME # 0024968 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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	EILEEN CONWAY	PRESIDENT	FINANCE	100.00	0	40	100.00	SALARY	$ 155,000	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	$ 155,000		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: 07/01/2009 Ending: 6/30/2010

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 [X]

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

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

	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						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BELMONT NURSING HOME # 0024968 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	COMMUNITY BANK		X	LINE OF CREDIT	INT ONLY		100,000	100,086	REVOLVING		2,314	6
7	SHAREHOLDER LOAN	X		WORKING CAPITAL	$6,712.94	2/2/09	530,250	455,897	02/1/17	5.0000	24,329	7
8	INLAND BANK		X	WORKING CAPITAL				190,704			12,365	8
9	TOTAL Facility Related				$6,712.94		$ 630,250	$ 746,687			$ 39,008	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11	SHAREHOLDER LOAN	X			$1,003.00	05/21/10	50,000	49,619	5/21/15	4.2500	82	11
12												12
13												13
14	TOTAL Non-Facility Related				$1,003.00		$ 50,000	$ 49,619			$ 82	14
15	TOTALS (line 9+line14)						$ 680,250	$ 796,306			$ 39,090	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # 36

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

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

Facility Name & ID Number BELMONT NURSING HOME # 0024968 **Report Period Beginning:** 07/01/2009 **Ending:** 06/30/2010

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.**	$ 35,029	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.)		$ 71,780	2
3. Under or (over) accrual (line 2 minus line 1).		$ 36,751	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 31,289	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** $ 11,503 **For** 2006 **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$ (11,503)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 56,537	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005	53,994	8
2006	68,091	9
2007	67,364	10
2008	68,040	11
2009		12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON 102% OF 2008 BILLS LESS THE 1ST INSTALLMENT OF THE 2009 TAX BILL

	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 BELMONT NURSING HOME COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0024968

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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 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.	14-19-432-030-0000	NURSING HOME	$ 5,847.56	$ 5,847.56
2.	14-19-432-031-0000	NURSING HOME	$ 14,879.41	$ 14,879.41
3.	14-19-432-032-000	NURSING HOME	$ 27,865.97	$ 27,865.97
4.			$	$
5.			$	$
6.		2009 TAX BILLS WILL NOT	$	$
7.		AVAILABLE UNTIL ENDED	$	$
8.		OF NOVEMBER 2010	$	$
9.			$	$
10.			$	$
		TOTALS	$ 48,592.94	$ 48,592.94

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 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 BELMONT NURSING HOME # 0024968 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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. [X] (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. [ ] (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).

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		15,624		$ 46,250	1
2					2
3	TOTALS	15,624		$ 46,250	3

Facility Name & ID Number BELMONT NURSING HOME # 0024968 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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	61		1979	1919	$ 138,750	$		$	$	$ 138,750	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS			84	9,518		20			9,518	9
10	VARIOUS			88	4,145		20			4,145	10
11	VARIOUS			89	5,009	9	20	9		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	3,604	20	3,604		63,070	15
16	RADIATOR COVERS			94	1,404	70	20	70		1,155	16
17	FAUCETS & COURTERS			94	2,192	110	20	110		1,815	17
18	PRIVACY SCREENS			94	2,182	109	20	109		1,798	18
19	REMODELING			94	89,471	4,474	20	4,474		73,821	19
20	HEATER			94	1,011	51	20	51		841	20
21	BREAKER PANELS			94	1,355	68	20	68		1,122	21
22	BREAKER PANELS			94	1,155	58	20	58		957	22
23	REMODELING			95	107,660	5,383	20	5,383		83,437	23
24	ROOF			96	4,921	246	20	246		3,533	24
25	GLASS BLOCK WINDOW, NEW A/C			96	30,000	1,500	20	1,500		21,768	25
26	REMOVE BRICK FENCE, REMOVE METAL OVERHANG			96	46,977	2,349	20	2,349		34,073	26
27	NEW WOOD OVERHANG, IRON RAILINGS, ETC			96	50,000	2,500	20	2,500		36,253	27
28	FURANCE			97	3,820	191	20	191		2,579	28
29	NEW CHIMNEYS, NEW DOWNSPROUTS, NEW FLOOR			97	30,000	1,500	20	1,500		20,234	29
30	FAUCETS & FLOORS, WINDOWS, HOT WATER HEATER			97	53,500	2,675	20	2,675		36,110	30
31	DRYWALL & DOORS IN BASEMENTS, NEW TILES			97	42,500	2,125	20	2,125		28,693	31
32	DOORS, REPLACE TILES, NEW FIXTURES, FAUCETS, TUCKP			97	7,500	375	20	375		5,076	32
33	TUCKPOINTING, PAINTING, REPAIR WALLS, SKYLIGHT			98	43,807	2,190	20	2,190		27,375	33
34	BUILD SCREENED IN PORCH			98	3,295	165	20	165		2,062	34
35	FIRE DOORS, TILING, LIGHT FIXTURES, PAINTING			98	18,600	930	20	930		11,625	35
36	ALUMINUM GUTTERS & DOWNSPOUTS			99	4,350	217	20	217		2,496	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 & ID Number BELMONT NURSING HOME # 0024968 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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	PIPED & WIRED A/C RECEPTACLE A/C	2000	$ 7,045	$ 352	20	$ 352	$	$ 3,696	37
38	INSTALL WOOD DOOR, LIGHT FIXTURES, PAINTING	2000	4,825	241	20	241		2,531	38
39	PAINTING, LIGHT FIXTURES, TILE FLOORS	2000	4,100	205	20	205		2,153	39
40	FIRE SYSTEM	2000	1,645	82	20	82		861	40
41	REPLACE SIDEWALKS AND STAIRS	2000	3,100	155	20	155		1,628	41
42	SUPPLY & INSTALL 4 BATHROOM SINKS, FAUCETS, PLUM	2000	2,650	133	20	133		1,396	42
43	CUSTOM COUNTERS FOR NURSING STATION	2000	2,625	131	20	131		1,376	43
44	CUSTOM BUILD & INSTALL CABINETS IN MED ROOM	2000	3,750	188	20	188		1,974	44
45	FIRE SPRINKLER SYSTEM	2001	7,272	364	20	364		3,458	45
46	23 EXIT SIGNS	2001	4,108	205	20	205		1,948	46
47	FIRE PROTECTION SYSTEM	2001	4,959	248	20	248		2,356	47
48	FIRE ALARM	2002	935	47	20	47		399	48
49	PIPED & WIRED A/C RECEPTACLE A/C	2003	4,759	238	20	238		1,785	49
50	TILING	2004	16,415	821	20	821		5,336	50
51	FENCE	2004	3,276	164	20	164		1,066	51
52	ELECTRICAL WORK	2005	2,500	125	20	125		688	52
53	TILING	2005	1,500	75	20	75		413	53
54	SPRINKLER HEADS FOR FIRE PROTECTION	2006	4,450	223	20	223		1,003	54
55	FIRE ESCAPE REPAIR	2006	3,150	158	20	158		711	55
56	WINDOW TREATMENTS	2006	721	36	20	36		162	56
57	NEW FIRE ALARM SYSTEM	2007	62,645	3,132	20	3,132		10,962	57
58	TUCKPOINTING BUILDING	2007	8,850	442	20	442		1,547	58
59	NEW SIDEWALKS	2007	5,828	292	20	292		1,022	59
60	REPAIR ROOF, SKYLIGHT & DOWNSPROUTS	2007	5,450	272	20	272		952	60
61	REPAIR FENCE, GATES AND STAIR RAILINGS	2007	4,050	202	20	202		707	61
62	DRAW NEW FIRE ALARM SYSTEM	2007	5,260	264	20	264		924	62
63	NEW DOOR AND LOCK IN KITCHEN	2007	1,652	82	20	82		287	63
64	NEW HEATING & AIR CONDITIONING SYSTEM	2008	9,380	469	20	469		1,173	64
65	NEW ROOF	2008	21,270	1,064	20	1,064		2,660	65
66	FIRE ALARM PROTECTION INSTALLATION	2008	3,844	192	20	192		480	66
67	LAMINATE FLOORING	2008	8,085	404	20	404		1,010	67
68	PAINTING ALL ROOMS, HALLWAYS, OFFICES, ETC	2008	40,405	2,020	20	2,020		5,050	68
69	NEW FLOORING	2010	7,161	179	20	179		179	69
70	TOTAL (lines 4 thru 69)		$ 1,054,191	$ 44,104		$ 44,104	$	$ 690,508	70

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

Facility Name & ID Number BELMONT NURSING HOME # 0024968 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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		$ 1,054,191	$ 44,104		$ 44,104	$	$ 690,508	1
2	SPRINKLER HEADS FOR FIRE PROTECTION	2010	3,490	87	20	87		87	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	TOTAL (lines 1 thru 33)		$ 1,057,681	$ 44,191		$ 44,191	$	$ 690,595	34

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

Facility Name & ID Number BELMONT NURSING HOME # 0024968 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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	$ 100,724	$ 7,962	$ 7,962	$	10 YRS	$ 80,212	71
72	Current Year Purchases	7,978	399	399		10 YRS	399	72
73	Fully Depreciated Assets	217,178					217,178	73
74								74
75	TOTALS	$ 325,880	$ 8,361	$ 8,361	$		$ 297,789	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				$	$	$	$		$	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)	$ 1,429,811	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 52,552	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 52,552	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 988,384	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.

Facility Name & ID Number BELMONT NURSING HOME # 0024968 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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. [X] 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		$ 280,723	10		3
4	Additions							4
5								5
6								6
7	TOTAL		61		$ 280,723 **			7

8. List separately any amortization of lease expense included on page 4, line 34. 2,500
   This amount was calculated by dividing the total amount to be amortized 300,000
   by the length of the lease 10 YRS .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning 06/01/06
    Ending 05/31/16

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

	Fiscal Year Ending	Annual Rent
12.	05/31/2011	$ 174,000
13.	05/31/2012	$ 174,000
14.	05/31/2013	$ 174,000

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 750 Description: DISHWASHER RENTAL - 10 MONTHS @ $75
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number BELMONT NURSING HOME # 0024968 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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

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

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

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.

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	39-3	hrs	$		$ 0	$		$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			0				2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			0				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			0	0			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			$		$ 0	$ 0		$	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.

STATE OF ILLINOIS

Facility Name & ID Number BELMONT NURSING HOME # 0024968 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2010 (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	$ 88,517	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	691,784		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	50,144		6
7	Other Prepaid Expenses	2,781		7
8	Accounts Receivable (owners or related parties)	20,639		8
9	Other(specify): REAL ESTATE ESCROW DEP	186		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 854,051	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	46,250		13
14	Buildings, at Historical Cost	138,750		14
15	Leasehold Improvements, at Historical Cost	918,932		15
16	Equipment, at Historical Cost	325,881		16
17	Accumulated Depreciation (book methods)	(260,459)		17
18	Deferred Charges	694		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): PREPAID RENT	177,500		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,347,548	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,201,599	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 34,503	$	26
27	Officer's Accounts Payable	49,619		27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	59,102		29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	31,289		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 174,513	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	687,585		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)**	$ 687,585	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 862,098	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,339,501	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,201,599	$	48

***(See instructions.)**

Facility Name & ID Number BELMONT NURSING HOME # 0024968 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,300,090	1
2	Restatements (describe):		2
3	ROUNDING	3	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,300,093	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	39,408	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)**	$ 39,408	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)**	$ 1,339,501	24 *

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

Facility Name & ID Number BELMONT NURSING HOME # 0024968 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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	$ 2,218,799	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,218,799	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	920	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 920	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,219,719	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	461,687	31
32	Health Care	630,630	32
33	General Administration	623,243	33
	B. Capital Expense		
34	Ownership	430,353	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	33,398	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES	1,000	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,180,311	40
41	**Income before Income Taxes (line 30 minus line 40)****	39,408	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 39,408	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.**
TAX RETURN PREPARED ON CASH BASIS

*** **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: 07/01/2009 Ending: 06/30/2010

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	1,960	2,080	$ 71,557	$ 34.40	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	8,875	9,635	229,003	23.77	4
5	CNAs & Orderlies	13,013	13,910	126,044	9.06	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,577	1,841	21,131	11.48	9
10	Activity Assistants	581	581	4,514	7.77	10
11	Social Service Workers	490	626	55,284	88.31	11
12	Dietician					12
13	Food Service Supervisor	1,403	1,773	30,651	17.29	13
14	Head Cook	2,540	2,676	34,964	13.07	14
15	Cook Helpers/Assistants					15
16	Dishwashers	5,582	5,806	56,049	9.65	16
17	Maintenance Workers	3,062	3,251	55,626	17.11	17
18	Housekeepers	4,922	5,295	51,868	9.80	18
19	Laundry					19
20	Administrator	1,960	2,080	56,030	26.94	20
21	Assistant Administrator	1,960	2,080	31,200	15.00	21
22	Other Administrative	1,960	2,080	155,000	74.52	22
23	Office Manager					23
24	Clerical	495	771	8,625	11.19	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	3,920	4,160	93,600	22.50	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)	54,300	58,645	$ 1,081,146 *	$ 18.44	34

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

** See instructions.

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	48	$ 2,640	1-3	35
36	Medical Director		0	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	32	1,469	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant		0	11-3	44
45	Social Service Consultant	36	2,060	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	116	$ 6,169		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	188	$ 5,650	10-3	50
51	Licensed Practical Nurses	8	277	10-3	51
52	Certified Nurse Assistants/Aides	8	150	10-3	52
53	TOTAL (lines 50 - 52)	204	$ 6,077		53

Facility Name & ID Number BELMONT NURSING HOME # 0024968 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
LAURIE HERTZ	ADMINISTRATOR		$ 56,030
MILDRED SHEPPARD	ASST ADMIN		31,200
EILEEN CONWAY	OTHER ADMIN		155,000
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 242,230

B. Administrative - Other

Description	Amount
	$ 0
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
R J ACHILLE & CO	ACCOUNTING	$ 38,215
KRUPNICK BOKOR	ACCOUNTING	4,000
KEVIN CONWAY	LEGAL	1,083
SCHMIDT SALZMAN & MORAN	LEGAL	14,451
COMCAST CABLE	INTERNET	919
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 58,668

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 23,054
Unemployment Compensation Insurance	4,351
FICA Taxes	80,744
Employee Health Insurance	82,271
Employee Meals	3,263
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	23,928
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	3,567
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 221,178

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	199
Health Care Worker Background Check	368
(Indicate # of checks performed 23)	
Patient Background Checks	0
TRUST/FRANCHISE/CONTRIB/ETC	0
MARKETING/ADV/PROMO	0
LICENSES/DUES/SUBSCRIPTIONS	4,262
MGMT CO ALLOC	
TRUST/FRANCHISE/CONTRIB/ETC	0
Less: Public Relations Expense	(0)
Non-allowable advertising	(0)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,829

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

**See instructions.

Facility Name & ID Number BELMONT NURSING HOME # 0024968 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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	PAINT/DECORATING		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$ 0	$	$	$	$	$

Facility Name & ID Number BELMONT NURSING HOME **#** 0024968 **Report Period Beginning:** 07/01/2009 **Ending:** 06/30/2010

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 $3,660**

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

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

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **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. $ **33,398**
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. $ **3,263** 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 out of Schedule V? **YES**

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