

		FOR BHF USE					

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**2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)**

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.

<p>I. IDPH License ID Number: <u>0024968</u></p> <p>Facility Name: <u>BELMONT NURSING HOME</u></p> <p>Address: <u>1936 WEST BELMONT AVENUE</u> <u>CHICAGO</u> <u>60657</u> <small>Number City Zip Code</small></p> <p>County: <u>COOK</u></p> <p>Telephone Number: <u>(773) 525-7176</u> Fax # <u>(773) 525-8929</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>10/16/79</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;">IRS Exemption Code _____</td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>BOB KAGDA</u> Telephone Number: <u>(847) 675-3585</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/2010</u> to <u>06/30/2011</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px; vertical-align: top;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) <u>EILEEN CONWAY</u> (Title) <u>PRESIDENT</u></td> </tr> <tr> <td style="padding: 5px; vertical-align: top;">Paid Preparer</td> <td style="padding: 5px;">(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Print Name and Title) <u>BOB KAGDA VICE PRESIDENT</u> (Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD 3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u> (Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td> </tr> </table> <p align="right">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</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>EILEEN CONWAY</u> (Title) <u>PRESIDENT</u>	Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Print Name and Title) <u>BOB KAGDA VICE PRESIDENT</u> (Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD 3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u> (Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>
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Facility Name & ID Number BELMONT NURSING HOME

0024968 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	61	Intermediate (ICF)	61	22,265	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	61	TOTALS	61	22,265	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	18,726			18,726	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,726			18,726	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.11%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

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

I. On what date did you start providing long term care at this location?
Date started 10/16/79

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

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011

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

Facility Name & ID Number

BELMONT NURSING HOME

0024968

Report Period Beginning:

07/01/2010

Ending:

06/30/2011

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	133,470	26,434	2,688	162,592		162,592		162,592		1
2	Food Purchase		106,841		106,841	(3,986)	102,855	(624)	102,231		2
3	Housekeeping	42,924	72,932		115,856		115,856		115,856		3
4	Laundry										4
5	Heat and Other Utilities			32,954	32,954		32,954		32,954		5
6	Maintenance	75,917	66,103	871	142,891		142,891		142,891		6
7	Other (specify):*			8,766	8,766		8,766		8,766		7
8	TOTAL General Services	252,311	272,310	45,279	569,900	(3,986)	565,914	(624)	565,290		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	559,595	23,659	4,213	587,467		587,467		587,467		10
10a	Therapy										10a
11	Activities	24,044	13,324		37,368		37,368		37,368		11
12	Social Services	19,300		322	19,622		19,622		19,622		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	602,939	36,983	4,535	644,457		644,457		644,457		16
	C. General Administration										
17	Administrative	232,230			232,230		232,230		232,230		17
18	Directors Fees										18
19	Professional Services			49,949	49,949		49,949		49,949		19
20	Dues, Fees, Subscriptions & Promotions			15,884	15,884		15,884	(3,750)	12,134		20
21	Clerical & General Office Expenses		31,667	4,690	36,357		36,357		36,357		21
22	Employee Benefits & Payroll Taxes			207,759	207,759	3,986	211,745		211,745		22
23	Inservice Training & Education			254	254		254		254		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			4,910	4,910		4,910		4,910		25
26	Insurance-Prop.Liab.Malpractice			44,015	44,015		44,015		44,015		26
27	Other (specify):*										27
28	TOTAL General Administration	232,230	31,667	327,461	591,358	3,986	595,344	(3,750)	591,594		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,087,480	340,960	377,275	1,805,715		1,805,715	(4,374)	1,801,341		29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	2,688
	REPAIRS & MAINTENANCE	0
		0
		2,688
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	0
	ELECTRICITY	0
	WATER	0
	CABLE TV - LOBBY	666
	UTILITIES	32,288
		32,954
6	MAINTENANCE	
	GROUNDS MAINTENANCE	0
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	0
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	871
	FIRE SERVICE	0
		0
		0
		0
		0
		871
7	OTHER	
	SCAVENGER	8,766
	SECURITY SERVICE	0
		0
		0
		8,766
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	0
		0

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	825
	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	3,388
	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
		4,213
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 CONSULT 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	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
		0
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	322
		322
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES

PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	0
		0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	0
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	918
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	49,031
		0
		49,949
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	569
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	5,025
	LICENSES & PERMITS XIX F	6,180
	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	3,750
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	360
	PATIENT BACKGROUND CHECKS XIX F	0
		15,884
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	0
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	4,690
	MESSENGER SERVICE	0
		4,690

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	68,630
	UNEMPLOYMENT COMPENSATION XIX D	9,510
	WORKERS COMPENSATION INSURANC XIX D	22,008
	HOSPITALIZATION INSURANCE XIX D	75,934
	EMPLOYEE BENEFITS - OTHER XIX D	3,217
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	28,460
	CHICAGO HEAD TAX XIX D	0
		207,759
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	254
		254
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	
	TRAVEL XIX G	0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	4,910
		4,910
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	44,015
		44,015
27	OTHER	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

377,275

**BELMONT NURSING HOME
SCHEDULES
06/30/2011**

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

TOTAL FOOD PURCHASE	106,841
LESS SALES TAX	<u>(624)</u>
NET FOOD	106,217
TOTAL PATIENT CENSUS	18,726
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	56,178
ADD # EMPLOYEE MEALS/DAY	<u>6</u>
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	2,190
PATIENT MEALS	56,178
ADD EMPLOYEE MEALS	<u>2,190</u>
TOTAL MEALS/YEAR	58,368
NET FOOD	106,217
DIVIDE TOTAL MEALS/YEAR	<u>58,368</u>
COST PER MEAL	1.82
TIME EMPLOYEE MEALS	<u>2,190</u>
EMPLOYEE MEAL RECLASSIFICATION	<u>3,986</u>
	=====

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			55,952	55,952		55,952		55,952			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			35,822	35,822		35,822	(812)	35,010			32
33	Real Estate Taxes			47,881	47,881		47,881		47,881			33
34	Rent-Facility & Grounds			289,933	289,933		289,933		289,933			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			429,588	429,588		429,588	(812)	428,776			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)	1,087,480	340,960	840,261	2,268,701		2,268,701	(5,186)	2,263,515			45

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

BELMONT NURSING HOME

ID# 0024968

Report Period Beginning: 07/01/2010

Ending: 06/30/2011

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	DEFERRED MAINTENANCE	\$	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
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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:

07/01/2010

Ending:

06/30/2011

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	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(624)	0	0	0	0	0	0	0	0	0	0	(624)	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	(624)	0	0	0	0	0	0	0	0	0	0	(624)	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	(3,750)	0	0	0	0	0	0	0	0	0	0	(3,750)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(3,750)	0	0	0	0	0	0	0	0	0	0	(3,750)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(4,374)	0	0	0	0	0	0	0	0	0	0	(4,374)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BELMONT NURSING HOME# 0024968

Report Period Beginning:

07/01/2010 Ending:06/30/2011

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(812)	0	0	0	0	0	0	0	0	0	0	(812)	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	(812)	0	0	0	0	0	0	0	0	0	0	(812)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(5,186)	0	0	0	0	0	0	0	0	0	0	(5,186)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

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

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

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

07/01/2010

Ending:

06/30/2011

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	EILEEN CONWAY	PRESIDENT	FINANCE	100.00		40	100.00	SALARY	\$ 145,000	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	\$ 145,000		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:

07/01/2010

Ending: 6/30/2011

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

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

Facility Name & ID Number

BELMONT NURSING HOME

0024968

Report Period Beginning:

07/01/2010

Ending:

06/30/2011

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				1,843	6								
7	SHAREHOLDER LOAN	X		WORKING CAPITAL	\$6,712.94	2/2/09	530,250	396,794	2/17/17	5.0000	21,463	7								
8	INLAND BANK		X	WORKING CAPITAL	\$2,200.00	10/19/05		176,442	10/19/12	6.5000	12,138	8								
9	TOTAL Facility Related				\$8,912.94		\$ 630,250	\$ 573,236			\$ 35,444	9								
	B. Non-Facility Related*																			
10	IRS, IDR, ETC											10								
11	SHAREHOLDER LOAN	X			\$462.87	5/21/10	50,000			4.2500	378	11								
12												12								
13												13								
14	TOTAL Non-Facility Related				\$462.87		\$ 50,000	\$			\$ 378	14								
15	TOTALS (line 9+line14)						\$ 680,250	\$ 573,236			\$ 35,822	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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2010 report.		\$	31,289	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.)		\$	38,526	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	7,237	3	
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	48,147	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 \$ <u>7,503</u> For <u>2007</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	(7,503)	6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	47,881	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2006	<u>68,091</u>	<u>8</u>		
	2007	<u>67,364</u>	<u>9</u>		
	2008	<u>68,040</u>	<u>10</u>		
	2009	<u>48,593</u>	<u>11</u>		
	2010	<u>49,915</u>	<u>12</u>		
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED				FOR BHF USE ONLY	
ON THE 2ND INSTALLMENT OWED ON THE 2010 TAX BILL (23,189)				13	13
PLUS 50% OF THE 2010 REAL ESTATE TAX BILL (49,915.13 / 2= 24,958)				14	14
				15	15
				16	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.

Facility Name & ID Number BELMONT NURSING HOME

0024968

Report Period Beginning:

07/01/2010 Ending:

06/30/2011

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 10,248 B. General Construction Type: Exterior BRICK Frame IRON & WOOD Number of Stories _____

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

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

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

N/A

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

1. Total Amount Incurred: _____ 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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1		<u>15,624</u>		<u>\$ 46,250</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	15,624		\$ 46,250	3

Facility Name & ID Number BELMONT NURSING HOME

0024968

Report Period Beginning:

07/01/2010

Ending:

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	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		66,674	15
16	RADIATOR COVERS			94	1,404	70	20	70		1,225	16
17	FAUCETS & COURTERS			94	2,192	110	20	110		1,925	17
18	PRIVACY SCREENS			94	2,182	109	20	109		1,907	18
19	REMODELING			94	89,471	4,474	20	4,474		78,295	19
20	HEATER			94	1,011	51	20	51		892	20
21	BREAKER PANELS			94	1,355	68	20	68		1,190	21
22	BREAKER PANELS			94	1,155	58	20	58		1,015	22
23	REMODELING			95	107,660	5,383	20	5,383		88,820	23
24	ROOF			96	4,921	246	20	246		3,779	24
25	GLASS BLOCK WINDOW, NEW A/C			96	30,000	1,500	20	1,500		23,268	25
26	REMOVE BRICK FENCE, REMOVE METAL OVERHANG			96	46,977	2,349	20	2,349		36,422	26
27	NEW WOOD OVERHANG, IRON RAILINGS, ETC			96	50,000	2,500	20	2,500		38,753	27
28	FURANCE			97	3,820	191	20	191		2,770	28
29	NEW CHIMNEYS, NEW DOWNSPROUTS, NEW FLOOR			97	30,000	1,500	20	1,500		21,734	29
30	FAUCETS & FLOORS, WINDOWS, HOT WATER HEATER			97	53,500	2,675	20	2,675		38,785	30
31	DRYWALL & DOORS IN BASEMENTS, NEW TILES			97	42,500	2,125	20	2,125		30,818	31
32	DOORS, REPLACE TILES, NEW FIXTURES, FAUCETS, TUCKP			97	7,500	375	20	375		5,451	32
33	TUCKPOINTING, PAINTING, REPAIR WALLS, SKYLIGHT			98	43,807	2,190	20	2,190		29,565	33
34	BUILD SCREENED IN PORCH			98	3,295	165	20	165		2,227	34
35	FIRE DOORS, TILING, LIGHT FIXTURES, PAINTING			98	18,600	930	20	930		12,555	35
36	ALUMINUM GUTTERS & DOWNSPOUTS			99	4,350	217	20	217		2,713	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:

07/01/2010 Ending: 06/30/2011

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	PIPED & WIRED A/C RECEPTACLE A/C	2000	\$ 7,045	\$ 352	20	\$ 352	\$	\$ 4,048	37
38	INSTALL WOOD DOOR, LIGHT FIXTURES, PAINTING	2000	4,825	241	20	241		2,772	38
39	PAINTING, LIGHT FIXTURES, TILE FLOORS	2000	4,100	205	20	205		2,358	39
40	FIRE SYSTEM	2000	1,645	82	20	82		943	40
41	REPLACE SIDEWALKS AND STAIRS	2000	3,100	155	20	155		1,783	41
42	SUPPLY & INSTALL 4 BATHROOM SINKS, FAUCETS, PLUM	2000	2,650	133	20	133		1,529	42
43	CUSTOM COUNTERS FOR NURSING STATION	2000	2,625	131	20	131		1,507	43
44	CUSTOM BUILD & INSTALL CABINETS IN MED ROOM	2000	3,750	188	20	188		2,162	44
45	FIRE SPRINKLER SYSTEM	2001	7,272	364	20	364		3,822	45
46	23 EXIT SIGNS	2001	4,108	205	20	205		2,153	46
47	FIRE PROTECTION SYSTEM	2001	4,959	248	20	248		2,604	47
48	FIRE ALARM	2002	935	47	20	47		446	48
49	PIPED & WIRED A/C RECEPTACLE A/C	2003	4,759	238	20	238		2,023	49
50	TILING	2004	16,415	821	20	821		6,157	50
51	FENCE	2004	3,276	164	20	164		1,230	51
52	ELECTRICAL WORK	2005	2,500	125	20	125		813	52
53	TILING	2005	1,500	75	20	75		488	53
54	SPRINKLER HEADS FOR FIRE PROTECTION	2006	4,450	223	20	223		1,226	54
55	FIRE ESCAPE REPAIR	2006	3,150	158	20	158		869	55
56	WINDOW TREATMENTS	2006	721	36	20	36		198	56
57	NEW FIRE ALARM SYSTEM	2007	62,645	3,132	20	3,132		14,094	57
58	TUCKPOINTING BUILDING	2007	8,850	442	20	442		1,989	58
59	NEW SIDEWALKS	2007	5,828	292	20	292		1,314	59
60	REPAIR ROOF, SKYLIGHT & DOWNSPROUTS	2007	5,450	272	20	272		1,224	60
61	REPAIR FENCE, GATES AND STAIR RAILINGS	2007	4,050	202	20	202		909	61
62	DRAW NEW FIRE ALARM SYSTEM	2007	5,260	264	20	264		1,188	62
63	NEW DOOR AND LOCK IN KITCHEN	2007	1,652	82	20	82		369	63
64	NEW HEATING & AIR CONDITIONING SYSTEM	2008	9,380	469	20	469		1,642	64
65	NEW ROOF	2008	21,270	1,064	20	1,064		3,724	65
66	FIRE ALARM PROTECTION INSTALLATION	2008	3,844	192	20	192		672	66
67	LAMINATE FLOORING	2008	8,085	404	20	404		1,414	67
68	PAINTING ALL ROOMS, HALLWAYS, OFFICES, ETC	2008	40,405	2,020	20	2,020		7,070	68
69	NEW FLOORING	2010	7,161	179	20	179		358	69
70	TOTAL (lines 4 thru 69)		\$ 1,054,191	\$ 44,104		\$ 44,104	\$	\$ 734,603	70

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,054,191	\$ 44,104		\$ 44,104	\$	\$ 734,603	1
2	SPRINKLER HEADS FOR FIRE PROTECTION	2010	3,490	175	20	175		262	2
3	CEMENT WORK IN PATIO	2011	2,925	73		73		73	3
4	INSTALL 6' HIGH CINDER BLOCK WALL	2011	2,765	69		69		69	4
5	CUBICLE CURTAINS & TRACKS	2011	20,925	523		523		523	5
6	FENCE	2011	4,373	109		109		109	6
7	REDO OPENING INTO KITCHEN (DOOR,FRAME,HDWARE)	2011	5,662	142		142		142	7
8	NEW PIPING, MOP BASIN,AND FAUCETS	2011	4,498	112		112		112	8
9	NEW ELECTRICAL PIPING FOR NEW WATER HEATER	2011	3,821	96		96		96	9
10	SHOWER ROOM REHAB	2011	32,680	817		817		817	10
11	EXTERIOR STEEL STAIRWAY	2011	20,173	504		504		504	11
12	CIRCUITS FOR A/C UNITS	2011	9,765	244		244		244	12
13	REPAIR OPEN AREAS IN WALLS & CEILINGS	2011	6,852	171		171		171	13
14	REDO OPENING INTO CONF ROOM (DOOR,FRAME,HDWE)	2011	4,800	120		120		120	14
15	SPRINKLER HEADS	2011	5,900	148		148		148	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,182,820	\$ 47,407		\$ 47,407	\$	\$ 737,993	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 48,709	\$ 5,545	\$ 5,545	\$	10 YRS	\$ 26,163	71
72	Current Year Purchases	59,993	3,000	3,000		10YRS		72
73	Fully Depreciated Assets	277,171					277,171	73
74								74
75	TOTALS	\$ 385,873	\$ 8,545	\$ 8,545	\$		\$ 303,334	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,614,943	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 55,952	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 55,952	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)	\$ 1,041,327	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: **GENEVA INC CO**

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1999	61		\$ 289,933	10		3
4	Additions							4
5								5
6								6
7	TOTAL		61		\$ 289,933			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: _____*

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: **SEE SCHEDULE ATTACHED**

(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

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. 05/31/12 \$ 174,000

13. 05/31/13 \$ 174,000

14. 05/31/14 \$ 174,000

* 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.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
<p>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>		

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	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		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							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		\$ 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.

Facility Name & ID Number **BELMONT NURSING HOME**# **0024968**Report Period Beginning: **07/01/2010**Ending: **06/30/2011****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **06/30/2011**

(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	\$ 327,230	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)			3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	38,704		6
7	Other Prepaid Expenses	2,781		7
8	Accounts Receivable (owners or related parties)	31,424		8
9	Other(specify): Real Estate Escrow Dep.	18,994		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 419,133	\$	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	1,044,071		15
16	Equipment, at Historical Cost	385,873		16
17	Accumulated Depreciation (book methods)	(316,411)		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 (spe DEP FIXED ASSET)	10,399		22
23	Other(specify): RENT SECUR DEPOSIT	147,500		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,457,126	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,876,259	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 11,801	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	48,147		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)	\$ 59,948	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	573,236		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)	\$ 573,236	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 633,184	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,243,075	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,876,259	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,339,501	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,339,501	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(96,426)	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)	\$ (96,426)	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)	\$ 1,243,075	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number BELMONT NURSING HOME

0024968

Report Period Beginning: 07/01/2010

Ending: 06/30/2011

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,171,463	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,171,463	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***	812	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 812	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)	\$ 2,172,275	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	569,900	31
32	Health Care	644,457	32
33	General Administration	591,358	33
B. Capital Expense			
34	Ownership	429,588	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		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,268,701	40
41	Income before Income Taxes (line 30 minus line 40)**	(96,426)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (96,426)	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: 07/01/2010

Ending:

06/30/2011

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,912	2,080	\$ 80,294	\$ 38.60	1
2	Assistant Director of Nursing					2
3	Registered Nurses	482	482	19,300	40.04	3
4	Licensed Practical Nurses	8,353	9,057	226,612	25.02	4
5	CNAs & Orderlies	13,049	14,034	132,969	9.47	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,309	1,574	19,678	12.50	9
10	Activity Assistants	511	511	4,366	8.54	10
11	Social Service Workers	877	965	19,300	20.00	11
12	Dietician					12
13	Food Service Supervisor	1,508	1,852	35,183	19.00	13
14	Head Cook	4,120	4,388	43,413	9.89	14
15	Cook Helpers/Assistants					15
16	Dishwashers	4,283	4,935	54,874	11.12	16
17	Maintenance Workers	5,455	6,120	75,917	12.40	17
18	Housekeepers	3,650	3,971	42,924	10.81	18
19	Laundry					19
20	Administrator	1,920	2,080	56,030	26.94	20
21	Assistant Administrator	1,920	2,080	31,200	15.00	21
22	Other Administrative	1,960	2,080	145,000	69.71	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	3,771	4,187	100,420	23.98	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	55,080	60,396	\$ 1,087,480 *	\$ 18.01	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	48	\$ 2,688	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	Monthly fee	3,388	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	6	322	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	54	\$ 6,398		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses	32	825	10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)	32	\$ 825		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Laurie Hertz	ADMINISTRATOR		\$ 56,030	Workers' Compensation Insurance	\$ 22,008	IDPH License Fee	\$	
Mildred Sheppard	ASST ADMIN		31,200	Unemployment Compensation Insurance	9,510	Advertising: Employee Recruitment	569	
Eileen Conway	OTHER ADMIN		145,000	FICA Taxes	68,630	Health Care Worker Background Check	360	
				Employee Health Insurance	75,934	(Indicate # of checks performed _____)		
				Employee Meals	3,986	Patient Background Checks	0	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	3,750	
				EMPLOYEE BENEFITS - OTHER	3,217	MARKETING/ADV/PROMO	0	
				EMPLOYEE PHYSICAL EXAMS	0	LICENSES/DUES/SUBSCRIPTIONS	11,205	
				PENSION/PROFIT SHARING PLANS	28,460	MGMT CO ALLOC		
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(3,750)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(0)	
						Yellow page advertising	(0)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 232,230	TOTAL (agree to Schedule V, line 22, col.8)	\$ 211,745	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 12,134	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$ 0			\$	Out-of-State Travel	\$
							In-State Travel	0
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				Seminar Expense	0
C. Professional Services				TOTAL			Entertainment Expense	
Vendor/Payee	Type		Amount				(agree to Sch. V, line 24, col. 8)	
R J Achille & Co	ACCOUNTING		\$ 41,541					
Krupnick Bokor	ACCOUNTING		4,000					
Kevin Conway	LEGAL		1,500					
Schmidt Salzman & Moran	LEGAL		1,990					
Comcast Cable	INTERNET		918					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 49,949					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number BELMONT NURSING HOME

0024968

Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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 \$4,026,II assoc. health \$732.00
- (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. \$ 3,986 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) 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.