FOR BHF USE

LL1

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

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

I. IDPH License ID Number: 0004499

Facility Name: Bel Wood Nursing Home

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

County: Peoria

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

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Amanda Springborn **Telephone Number:** (314) 925-3838
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/13 to 9/24/13 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

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

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

Facility Name & ID Number Bel Wood Nursing Home # 0004499 Report Period Beginning: 01/01/13 Ending: 9/24/13

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	300	Skilled (SNF)	300	80,100	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	300	TOTALS	300	80,100	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	2,499	1,167	3,738	7,404	8
9	SNF/PED					9
10	ICF	31,744	8,981		40,725	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	34,243	10,148	3,738	48,129	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.09%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 50 and days of care provided 3,738

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 9/24/13 Fiscal Year: 9/24/13

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

Facility Name & ID Number Bel Wood Nursing Home # 0004499 Report Period Beginning: 01/01/13 Ending: 9/24/13

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	503,930	35,971		539,901		539,901		539,901			1
2	Food Purchase		300,981		300,981		300,981	(10,181)	290,800			2
3	Housekeeping	233,497	46,602		280,099		280,099		280,099			3
4	Laundry	127,993	29,699	25,454	183,146		183,146	(678)	182,468			4
5	Heat and Other Utilities			247,121	247,121		247,121		247,121			5
6	Maintenance	69,303	13,455	142,213	224,971		224,971	4,660	229,631			6
7	Other (specify):*											7
8	TOTAL General Services	934,723	426,708	414,788	1,776,219		1,776,219	(6,199)	1,770,020			8
	B. Health Care and Programs											
9	Medical Director			3,753	3,753		3,753		3,753			9
10	Nursing and Medical Records	3,485,559	451,388	274,208	4,211,155		4,211,155		4,211,155			10
10a	Therapy											10a
11	Activities	187,711	4,245		191,956		191,956		191,956			11
12	Social Services	81,160		4,896	86,056		86,056		86,056			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,754,430	455,633	282,857	4,492,920		4,492,920		4,492,920			16
	C. General Administration											
17	Administrative	93,581		169,560	263,141		263,141	(169,560)	93,581			17
18	Directors Fees							73,531	73,531			18
19	Professional Services			134,727	134,727		134,727	132,193	266,920			19
20	Dues, Fees, Subscriptions & Promotions			19,045	19,045		19,045	(924)	18,121			20
21	Clerical & General Office Expenses	247,199	4,497	58,789	310,485		310,485	422,773	733,258			21
22	Employee Benefits & Payroll Taxes			538,654	538,654		538,654	860,310	1,398,964			22
23	Inservice Training & Education			4,033	4,033		4,033		4,033			23
24	Travel and Seminar			5,071	5,071		5,071		5,071			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			171,207	171,207		171,207	(153,400)	17,807			26
27	Other (specify):*											27
28	TOTAL General Administration	340,780	4,497	1,101,086	1,446,363		1,446,363	1,164,923	2,611,286			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,029,933	886,838	1,798,731	7,715,502		7,715,502	1,158,724	8,874,226			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Bel Wood Nursing Home #0004499 Report Period Beginning: 01/01/13 Ending: 9/24/13

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			158,051	158,051		158,051	22,805	180,856			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			47,397	47,397		47,397		47,397			35
36	Other (specify):*											36
37	**TOTAL Ownership**			205,448	205,448		205,448	22,805	228,253			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		109,708	307,162	416,870		416,870		416,870			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			395,225	395,225		395,225		395,225			42
43	Other (specify):* **Non-Allowable Cos**			60,839	60,839		60,839	(60,839)				43
44	**TOTAL Special Cost Centers**		109,708	763,226	872,934		872,934	(60,839)	812,095			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,029,933	996,546	2,767,405	8,793,884		8,793,884	1,120,690	9,914,574			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 Bel Wood Nursing Home # 0004499 Report Period Beginning: 01/01/13 Ending: 9/24/13

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	(5,811)	2		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	22,148	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(41,640)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(42,779)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (68,082)		$	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)	1,188,772		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 1,188,772		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 1,120,690		37

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

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

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

Bel Wood Nursing Home

ID# 0004499

Report Period Beginning: 01/01/13

Ending: 9/24/13

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Disallow Medicare Ancillary Costs	$ (23,949)	43	1
2	Employee Recognitions & Awards	(747)	22	2
3	Vending Machine Revenue	(4,370)	2	3
4	Disallow Cable TV	(16,389)	21	4
5	Offset Miscellaneous Revenue	(678)	4	5
6	Offset Telephone Revenue	(440)	21	6
7	Donations/Charitable	4,750	43	7
8	Offset Copy Revenue	(32)	21	8
9	Properly account for Background checks	(924)	20	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**	(42,779)		49

Facility Name & ID Number Bel Wood Nursing Home # 0004499 Report Period Beginning: 01/01/13 Ending: 9/24/13

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
Peoria County	100			N/A		

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	6	County Admin Facility Mgmt	$	Peoria County	100.00%	$ 4,660	$ 4,660	1
2	V	17	Management Fee	169,560	Peoria County	100.00%		(169,560)	2
3	V	18	County Board		Peoria County	100.00%	73,531	73,531	3
4	V	19	Professional Services	108,750	Peoria County	100.00%	240,943	132,193	4
5	V	21	Clerical Services		Peoria County	100.00%	439,634	439,634	5
6	V	22	IMRF & FICA		Peoria County	100.00%	926,059	926,059	6
7	V	22	Employee Benefits - U/C	7,688	Peoria County	100.00%	5,259	(2,429)	7
8	V	22	Employee Benefits - Work Comp	145,712	Peoria County	100.00%	99,678	(46,034)	8
9	V	22	Health Insurance	537,907	Peoria County	100.00%	367,969	(169,938)	9
10	V	30	Equipment Depreciation		Peoria County	100.00%	657	657	10
11	V								11
12	V								12
13	V								13
14	Total			$ 969,617			$ 2,158,390	$ * 1,188,772	14

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

Facility Name & ID Number Bel Wood Nursing Home # 0004499 Report Period Beginning: 01/01/13 Ending: 9/24/13

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Lynn Scott Pearson	Chairperson	Administrative	0.00	N/A	1	<1%	N/A	$ N/A	N/A	1
2	Robert Baietto	Vice-Chairperson	Administrative	0.00	N/A	1	<1%	N/A	N/A	N/A	2
3	Mary Ardapple	Member	Administrative	0.00	N/A	1	<1%	N/A	N/A	N/A	3
4	Brian Elsasser	Member	Administrative	0.00	N/A	1	<1%	N/A	N/A	N/A	4
5	Brad Harding	Member	Administrative	0.00	N/A	1	<1%	N/A	N/A	N/A	5
6	Phillip Salzer	Member	Administrative	0.00	N/A	1	<1%	N/A	N/A	N/A	6
7	Sharon Williams	Member	Administrative	0.00	N/A	1	<1%	N/A	N/A	N/A	7
8											8
9	James Dillon, a member of the Peoria County Board, is the lead plumbing contractor from Dillon Plumbing.										9
10	Mr. Dillon is not a member of the Health, Environmental and Welfare Issues Committee Board, which directly oversees Bel-Wood Nursing Home.										10
11	Andrew Rand, a member of the Peoria County Board, is CEO of Advanced Medical Transport (AMT). Bel-Wood uses AMT in the transportation of residents.										11
12	Mr. Rand is not a member of the Health, Environmental and Welfare Issues Committee Board, which directly oversees Bel-Wood Nursing Home.										12
13								TOTAL	$		13

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

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

Facility Name & ID Number Bel Wood Nursing Home # 0004499 Report Period Beginning: 01/01/13 Ending: 9/24/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Facility Management	Direct allocation per	1		$	$		$ 4,660	1
2	18	County Board	Maximus, Inc. Please	1					73,531	2
3	19	Professional Services	see attached schedule.	1					132,193	3
4	21	Clerical Services	Further detail	1					439,634	4
5	22	Employee Benefits-Health	available upon	1					(169,938)	5
6	22	Employee Benefits-Work Comp	request.	1					(46,034)	6
7	22	Employee Benefits-U/C		1					(2,429)	7
8	30	Equipment Depreciation							657	8
9										9
10	17	Management Fee	Direct Cost						(169,560)	10
11	22	IMRF	Direct Cost						534,243	11
12	22	FICA	Direct Cost						391,815	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					$	$		$ 1,188,772	25

Facility Name & ID Number Bel Wood Nursing Home # 0004499 Report Period Beginning: 01/01/13 Ending: 9/24/13

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Bond		X	New Facility	N/A	10/03/11	$ 42,000,000	$ 42,000,000	12/15/2041	0.0468	$	1
2												2
3				* New facility construction interest expense is recorded on Heddington Oaks								3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 42,000,000	$ 42,000,000			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 42,000,000	$ 42,000,000			$	15

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

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

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

Facility Name & ID Number Bel Wood Nursing Home # 0004499 Report Period Beginning: 01/01/13 Ending: 9/24/13

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2012	$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008		8
	2009		9
	2010		10
	2011		11
	2012	N/A	12

County facility-pays no real estate tax.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Bel Wood Nursing Home COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0004499

CONTACT PERSON REGARDING THIS REPORT Joyce Harmon

TELEPHONE (309) 677-6233 FAX #: (309) 495-4608

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

Enter the tax index number and real estate tax assessed for 2012 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2012.

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number Bel Wood Nursing Home # 0004499 Report Period Beginning: 01/01/13 Ending: 9/24/13

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Bel Wood Nursing Home # 0004499 Report Period Beginning: 01/01/13 Ending: 9/24/13

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	300		1969	1969	$ 3,123,273	$ 46,853	50	$ 46,853	$	$ 2,795,361	4
5			1975	1975	4,223	69	45	69		3,626	5
6			1986	1986	47,151		Various			47,151	6
7											7
8											8
	Improvement Type**										
9	Improvements			1978	10,851	203	40	203		9,715	9
10	Improvements			1979	23,127		20-25			23,127	10
11	Improvements			1980	115,619		20-25			115,619	11
12	Improvements			1984	15,544		Various			15,544	12
13	Improvements			1985	511,366		Various			511,366	13
14	Improvements			1986	45,660		20			45,660	14
15	Improvements			1987	936		Various			936	15
16	Improvements			1988	104,423		Various			104,423	16
17	Improvements (12,656 disposed 2011)			1989	145,485		Various			145,485	17
18	Improvements			1990	140,837		Various			140,837	18
19	Improvements			1991	599,124	22,467	Various	22,467		585,146	19
20	Improvements			1992	188,119		Various			188,119	20
21	Improvements			1995	4,885	183	16-20	183		4,390	21
22	Building Improvements (2009 - disposal of 8774)			1995	14,869		5-20			14,869	22
23	Resurface Driveway			1996	2,947	95	16	95		2,947	23
24	Telephone Wiring			1996	2,383	89	20	89		1,914	24
25	Faucets			1997	1,862	70	20	70		1,473	25
26	Replace Floor			1997	1,035	39	20	39		823	26
27	Remodeling			1997	1,291	49	20	49		1,056	27
28	Door Replacement			1997	4,957	186	20	186		4,113	28
29	Ceiling tile			1997	1,488		15			1,488	29
30	Concrete Slabs			1997	825	31	20	31		670	30
31	Sinks			1997	3,718	140	20	140		3,007	31
32	Plumbing			1997	2,397	72	25	72		1,552	32
33	Compressor (disposed of in 2009)			1997							33
34	Fireplace			1998	946	35	20	35		717	34
35	Bi-fold Doors			1998	27,343		10			27,343	35
36	Sink System			1998	2,569	96	20	96		1,974	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 Bel Wood Nursing Home # 0004499 Report Period Beginning: 01/01/13 Ending: 9/24/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Handrails	1998	$ 1,955	$	10	$	$	$ 1,955	37
38	Water Softener	1998	34,106		12			34,106	38
39	Roof Repair (Disposed 2011)								39
40	Wallpaper	1998	985	37	20	37		753	40
41	Wallpaper	1998	1,885	71	20	71		1,451	41
42	Wallpaper	1998	1,075	40	20	40		835	42
43	Wallpaper	1998	434	16		16		330	43
44	Roof Repair (Disposed 2011)								44
45	Undergoround Storage Tank	1998	26,041	488	40	488		10,253	45
46	Energy Management System Modifications	1999	3,732		10			3,732	46
47	Roof Repairs	2000	1,254	63	15	63		1,196	47
48	Architect fees per IDPA review of 1999 cost report	2000	15,290		8			15,290	48
49	Shelving, dish room	2000	1,500	56	20	56		1,012	49
50	Door relocation	2000	1,461	55	20	55		980	50
51	Roof Repairs	2000	3,552	178	15	178		3,159	51
52	Water Main #1	2000	3,178	95	25	95		1,683	52
53	Sidewalk Replacement	2000	1,350	51	20	51		900	53
54	Water Main #2	2000	2,120	64	25	64		1,111	54
55	Door guards	2000	1,694	64	20	64		1,104	55
56	Door, magnetic lock	2000	4,062	152	20	152		2,622	56
57	Replacement glass	2001	2,971	111	20	111		1,885	57
58	Fire System (Disposed 2011)								58
59	Water heater replacement	2001	84,666		8			84,666	59
60	Drawer front machine	2001	1,690	85	15	85		1,412	60
61	Windows	2002	59,439	2,229	20	2,229		32,692	61
62	Resident Alarm System	2002	43,538	1,633	20	1,633		23,584	62
63	Exit Device	2002	1,862	2	10	2		1,862	63
64	Egress Bars for Doors	2002	2,630		10			2,630	64
65	Rooftop Unit Pilot Program Phase 1	2002	1,420	71	15	71		1,021	65
66	Construction Documents	2002	6,750		8			6,750	66
67	Control Wiring	2002	2,495	94	20	94		1,417	67
68	Roof Repairs	2002	1,642	82	15	82		1,254	68
69	Exit Signs	2003	2,596	18	10	18		2,596	69
70	TOTAL (lines 4 thru 69)		$ 5,466,626	$ 76,432		$ 76,432	$	$ 5,044,692	70

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

Facility Name & ID Number Bel Wood Nursing Home # 0004499 Report Period Beginning: 01/01/13 Ending: 9/24/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,466,626	$ 76,432		$ 76,432	$	$ 5,044,692	1
2	Air Cylinder - Drain	2003	1,049	34	10	34		1,049	2
3	Zone Motor & Bases	2003	4,211	282	10	282		4,211	3
4	Construction Documentation	2003	12,854		8			12,854	4
5	Fence for Alzheimer Unit	2003	4,277	214	15	214		2,851	5
6	Parking lot overlay	2003	39,414	1,848	16	1,848		24,633	6
7	Water heater replacement	2003	52,500	2,625	15	2,625		35,000	7
8	Engineering	2003	3,700		8			3,700	8
9	Water main replacement	2003	80,810	2,424	25	2,424		31,783	9
10	Fire alarm panel replacement	2003	22,710	852	20	852		11,169	10
11	Reception Area Remodel	2003	2,904	109	20	109		1,415	11
12	Double Egress Doors	2004	2,585	194	10	194		2,393	12
13	Alzheimer Security	2004	26,381		5			26,381	13
14	Wallpaper HC & Norwood	2004	3,237		5			3,237	14
15	Blinds HC & Glasford	2004	6,070		5			6,070	15
16	Fire Alarm system	2004	111,652	8,374	10	8,374		101,417	16
17	Aluminum Awning (disposed of in 2009)	2004			10				17
18	Roof Repairs	2004	3,383	254	10	254		2,987	18
19	Fire alarm wiring	2004	5,812	436	10	436		5,085	19
20	Electrical service	2004	3,132	235	10	235		2,766	20
21	Compressor repairs (Disposed 2011)								21
22	Reception area shades	2004	2,062		5			2,062	22
23	Addition to watermain	2004	30,505	953	24	953		12,074	23
24	Door closer and locks	2004	2,366	177	10	177		2,248	24
25	Water heater replacement	2005	1,204		5			1,204	25
26	Roof Repairs - Massey	2005	15,793	1,184	10	1,184		12,369	26
27	Engine Control Panel	2005	35,025	1,313	20	1,313		14,738	27
28	Door closer and locks	2005	899	68	10	68		705	28
29	Carpeting	2005	1,735		5			1,735	29
30	Sink Repairs	2005	5,514		5			5,514	30
31	AA D379 Engine Repair (Disposed 2011)								31
32	Front Door Repair	2005	1,235		5			1,235	32
33	Carpeting	2005	1,563		5			1,563	33
34	TOTAL (lines 1 thru 33)		$ 5,951,208	$ 98,008		$ 98,008	$	$ 5,379,140	34

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

Facility Name & ID Number Bel Wood Nursing Home # 0004499 Report Period Beginning: 01/01/13 Ending: 9/24/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 5,951,208	$ 98,008		$ 98,008	$	$ 5,379,140	1
2	C-wing Faux Wood Blinds	2005	4,998		5			4,998	2
3	Water Softener Overhaul	2005	1,574		5			1,574	3
4	Smoke Detector	2005	1,710	128	10	128		1,482	4
5	4 Plexiglass Flower Boxes	2005	1,580		5			1,580	5
6	Domestic Hot Water Temp Valve (Disposed 2011)								6
7	Carpeting	2005	7,333		5			7,333	7
8	HVAC Repairs	2005	103,550		5			103,550	8
9	Booster Pump	2006	4,000		5			4,000	9
10	Doors and Locks	2006	8,760		5			8,760	10
11	Door Latch Replacement	2006	28,360		5			28,360	11
12	Roof Repairs (Disposed 2011)								12
13	HVAC Repairs (Disposed 2011)								13
14	Victory chiller swing door	2007	9,573	718	10	718		5,503	14
15	HVAC repairs	2007	44,128		3			44,128	15
16	Roof repairs	2007	9,240		3			9,240	16
17	Electrical upgrade	2007	42,840	3,213	10	3,213		24,633	17
18	Boiler pump	2007	3,274		5			3,274	18
19	Smoke dampers	2007	31,696	2,378	10	2,378		18,228	19
20	Fire Alarm	2007	6,770	508	10	508		4,399	20
21	Water back flows	2007	3,977		5			3,977	21
22	Outdoor walk-in freezer	2007	22,300	1,673	10	1,673		14,496	22
23	Carpeting	2007	3,172		5			3,172	23
24	Draper shades for hallway	2007	9,820		5			9,820	24
25	Disposal (disposed of in 2009	2007							25
26	Front Door Patient Alarm	2007	2,580		5			2,580	26
27	Firewall for IDPH	2007	3,450		5			3,450	27
28	Booster Pump	2007	47,390		5			47,390	28
29	Ceiling Tile Replacement	2007	15,493		5			15,493	29
30	Sidewalks	2007	4,060	305	10	305		2,538	30
31	Main Enterance Delayed Exit A	2008	3,415		3			3,415	31
32	HVAC Repairs	2008	64,942		3			64,942	32
33	Roof Repairs	2008	8,308		3			8,308	33
34	TOTAL (lines 1 thru 33)		$ 6,449,501	$ 106,931		$ 106,931	$	$ 5,829,763	34

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

Facility Name & ID Number Bel Wood Nursing Home # 0004499 Report Period Beginning: 01/01/13 Ending: 9/24/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 6,449,501	$ 106,931		$ 106,931	$	$ 5,829,763	1
2	Boiler Replacement	2008	18,200		3			18,200	2
3	Hot Water Heater Repairs	2008	3,606		3			3,606	3
4	Faux Wood Blinds	2008	22,596		3			22,596	4
5									5
6	HVAC Repairs	2009	76,683		2			76,683	6
7	Roof Repairs	2009	14,328		2			14,328	7
8	Flooring - First Floor	2009	4,657		2			4,657	8
9									9
10	Hammerall Disposer 3HP	2010	7,430		2			7,430	10
11	HVAC Repairs	2010	45,296		2			45,296	11
12	Roof Repairs	2010	8,789		2			8,789	12
13	Fusible Link/Booster heater	2010	6,539		2			6,539	13
14	Emergency Pump Repair	2010	3,154		2			3,154	14
15	Fauxwood Blinds	2010	2,773		2			2,773	15
16	Sidewalk Repair	2010	2,675		2			2,675	16
17									17
18	Boiler repair	2011	17,515	2,627	5	2,627		6,714	18
19	2011 HVAC repairs	2011	27,814	6,953	3	6,953		20,860	19
20	New Corridor doors	2011	4,460	669	5	669		2,156	20
21	Repipe Cold water	2011	2,556	383	5	383		937	21
22	2011 roof repairs	2011	11,990	1,799	5	1,799		5,396	22
23	Wet Sprinkler systems	2011	4,965	745	5	745		1,821	23
24	UPS	2011	2,558	384	5	384		1,067	24
25									25
26	HVAC Repairs - RTU 13, RTU 3, RTU 7 & RTU 5	2012	67,764	10,165	5	10,165		16,941	26
27	Roof Repairs - Whole Facility	2012	17,629	2,644	5	2,644		4,407	27
28	Accoustical Tile Repair - Therapy Room	2012	3,600	540	5	540		900	28
29									29
30									30
31	Adjust to financial statement information			(22,148)			22,148		31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,827,078	$ 111,692		$ 133,840	$ 22,148	$ 6,107,688	34

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

Facility Name & ID Number Bel Wood Nursing Home # 0004499 Report Period Beginning: 01/01/13 Ending: 9/24/13

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	$ 422,536	$ 40,829	$ 40,829	$		$ 322,414	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	669,231	1,455	1,455			669,231	73
74	Allocated from Peoria County			657	657			74
75	TOTALS	$ 1,091,767	$ 42,284	$ 42,941	$ 657		$ 991,645	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	Facility Maintenance	2000 Dodge Ram Truck	2000	$ 13,998	$	$	$	8	$ 13,998	76
77	Resident Transportation	1997 Ford El Dorado	1997	42,701				4	42,701	77
78	Facility Maintenance	2012 Ford F-250 4X2	2012	27,165	4,075	4,075		5	6,339	78
79										79
80	TOTALS			$ 83,864	$ 4,075	$ 4,075	$		$ 63,038	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)	$ 8,002,808	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 158,051	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 180,856	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 22,805	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 7,162,371	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	N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	CIP - New Building	$ 44,414,525	92
93	CIP - Fixture & Furniture	1,688,664	93
94			94
95		$ 46,103,189	95

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

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

Facility Name & ID Number Bel Wood Nursing Home # 0004499 Report Period Beginning: 01/01/13 Ending: 9/24/13

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2014	$
13.	/2015	$
14.	/2016	$

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: $ 47,397 Description: Medical Equipment - $35,688, Duplicating Equipment - $4,965, Software Maint/Lease - $6,744
    (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			$ N/A	$	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 Bel Wood Nursing Home # 0004499 Report Period Beginning: 01/01/13 Ending: 9/24/13

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

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Bel Wood Nursing Home # 0004499 Report Period Beginning: 01/01/13 Ending: 9/24/13

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39(2),(3)	hrs	$	1,816	$ 108,149	$ 1,117	1,816	$ 109,266	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,223	64,603		1,223	64,603	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		2,667	134,410		2,667	134,410	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				108,591		108,591	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			$	5,706	$ 307,162	$ 109,708	5,706	$ 416,870	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 Bel Wood Nursing Home # 0004499 Report Period Beginning: 01/01/13 Ending: 9/24/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/24/13 (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	$ 7,237,102	$ 7,237,102	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 298,448)	1,986,931	1,986,931	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	3,000,000	3,000,000	5
6	Prepaid Insurance	50,478	50,478	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Intangible Assets	59,595	59,595	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 12,334,106	$ 12,334,106	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	9	9	12
13	Land	821,367	100	13
14	Buildings, at Historical Cost	6,419,839	3,174,647	14
15	Leasehold Improvements, at Historical Cost	168,322	3,652,431	15
16	Equipment, at Historical Cost	1,175,630	1,175,630	16
17	Accumulated Depreciation (book methods)	(6,938,734)	(7,162,371)	17
18	Deferred Charges	4,233	4,233	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe CIP	46,103,189	46,103,189	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 47,753,855	$ 46,947,868	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 60,087,961	$ 59,281,974	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 291,204	$ 291,204	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	311,065	311,065	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	554,774	554,774	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	496,229	496,229	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,653,272	$ 1,653,272	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	42,000,000	42,000,000	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)**	$ 42,000,000	$ 42,000,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 43,653,272	$ 43,653,272	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 16,434,689	$ 15,628,702	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 60,087,961	$ 59,281,974	48

***(See instructions.)**

Bel-Wood Nursing Home
Provider ID#: 0004499
FYE 12/31/13

Supplementary Information

Schedule 17A

XV. BALANCE SHEET - Line 36 - Other Current Liabilities

	Operating	After Consolidation
Accrued Vacation & Comp Time	263,729	263,729
Due to State of Illinois	97,500	97,500
Deferred Revenue	135,000	135,000
Total P17 L 36	496,229	496,229

Facility Name & ID Number Bel Wood Nursing Home # 0004499 Report Period Beginning: 01/01/13 Ending: 9/24/13

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 15,710,394	1
2	Restatements (describe):		2
3	ROUNDING	(1)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 15,710,393	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	724,296	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)**	$ 724,296	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)**	$ 16,434,689	24 *

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

Facility Name & ID Number Bel Wood Nursing Home # 0004499 Report Period Beginning: 01/01/13 Ending: 9/24/13

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,083,465	1
2	Discounts and Allowances for all Levels	(1,895,857)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,187,608	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	553,873	6
7	Oxygen	47,208	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 601,081	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	101,111	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)**	$ 101,111	23
	D. Non-Operating Revenue		
24	Contributions	675	24
25	Interest and Other Investment Income***	7,039	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 7,714	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	See Schedule 19A	1,620,666	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,620,666	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,518,180	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,776,219	31
32	Health Care	4,492,920	32
33	General Administration	1,446,363	33
	B. Capital Expense		
34	Ownership	205,448	34
	C. Ancillary Expense		
35	Special Cost Centers	477,709	35
36	Provider Participation Fee	395,225	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,793,884	40
41	**Income before Income Taxes (line 30 minus line 40)****	724,296	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 724,296	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,995,516	44
45	Private Pay - Net Inpatient Revenue	1,933,762	45
46	Medicare - Net Inpatient Revenue	845,460	46
47	Other-(specify) Third Party	412,870	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,187,608	49

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

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

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

^ - County government files no tax return.

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

Bel-Wood Nursing Home
Provider ID#: 0004499
FYE: 9/24/13

Supplementary Information

Schedule 19A

XVII. INCOME STATEMENT - Line 28a - Other Revenue

	Amount
Miscellaneous Fee for Services	6,489
Property Tax	1,423,937
Copies	32
Vending Machine Revenue	4,370
Recovery of Bad Debt	185,838
Total P19 L 28a	1,620,666

Facility Name & ID Number Bel Wood Nursing Home # 0004499 Report Period Beginning: 01/01/13 Ending: 9/24/13

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	1,382	1,520	$ 72,230	$ 47.52	1
2	Assistant Director of Nursing	2,688	3,040	100,257	32.98	2
3	Registered Nurses	14,443	16,291	478,175	29.35	3
4	Licensed Practical Nurses	39,893	45,208	1,002,945	22.19	4
5	CNAs & Orderlies	110,010	124,013	1,805,101	14.56	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,288	1,520	38,037	25.02	9
10	Activity Assistants	8,189	9,601	149,674	15.59	10
11	Social Service Workers	2,766	3,395	81,160	23.91	11
12	Dietician					12
13	Food Service Supervisor	1,296	1,520	47,502	31.25	13
14	Head Cook	1,340	1,566	40,801	26.05	14
15	Cook Helpers/Assistants	26,248	30,211	415,627	13.76	15
16	Dishwashers					16
17	Maintenance Workers	2,498	2,836	69,303	24.44	17
18	Housekeepers	16,064	18,109	233,497	12.89	18
19	Laundry	7,615	8,772	127,993	14.59	19
20	Administrator	1,358	1,520	93,581	61.57	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,399	15,430	247,199	16.02	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,556	1,676	26,851	16.02	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	252,033	286,228	$ 5,029,933 *	$ 17.57	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		$		35
36	Medical Director	Monthly	3,753	9(3)	36
37	Medical Records Consultant	Monthly	1,470	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	4,896	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 10,119		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	736	$ 20,910	10(3)	50
51	Licensed Practical Nurses	6,207	185,548	10(3)	51
52	Certified Nurse Assistants/Aides	4,135	66,281	10(3)	52
53	TOTAL (lines 50 - 52)	11,078	$ 272,738		53

Facility Name & ID Number Bel Wood Nursing Home # 0004499 Report Period Beginning: 01/01/13 Ending: 9/24/13

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Matt Nieukirk	Administrator	0	$ 93,581
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 93,581

B. Administrative - Other

Description	Amount
Peoria County (Management Fee)	$ 169,560
Eliminated on P3, L17 C7	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 169,560
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
McGladrey LLP	Accounting	$ 10,970
Baker Tilly	Accounting	8,961
Matt Koch	Accounting	5,464
E-Health Data Solutions	Data Management	582
Peoria County	Data Processing	108,750
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 134,727

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 123,750
Unemployment Compensation Insurance	6,529
FICA Taxes	391,815
Employee Health Insurance	342,627
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	534,243
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,398,964

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,726
Health Care Worker Background Check	
(Indicate # of checks performed 10)	89
Patient Background Checks 111	987
Life Services Network of Illinois dues	13,794
Miscellaneous Dues & Subscriptions	265
Miscellaneous Fees	260
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,121

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	2,846
Seminar Expense	2,225
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,071

**See instructions.

Bel-Wood Nursing Home
Provider ID# 0004499
FYE 9/24/13

Schedule 21A

XIXI. Support Schedules - Section - Professional Services

	Amount
Per Schedule V, L19, C3	134,727
County Allocation	132,193
Per Schedule V, L19, C8	266,920

Facility Name & ID Number Bel Wood Nursing Home # 0004499 Report Period Beginning: 01/01/13 Ending: 9/24/13

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

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

Facility Name & ID Number Bel Wood Nursing Home # 0004499 Report Period Beginning: 01/01/13 Ending: 9/24/13

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. **LSN - $13,794**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **126,398** Line **10(2)**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **395,225**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **5,811**

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

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

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

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