FOR BHF USE

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

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.

I. IDPH License ID Number: 0034678

Facility Name: BELLEVILLE HLTHCARE & REHAB

Address: 150 NORTH 27TH ST (Number) BELLEVILLE (City) 62226 (Zip Code)

County: ST CLAIR

Telephone Number: (618) 235-6600 **Fax #** (618) 235-7555

HFS ID Number:

Date of Initial License for Current Owners: 09/88

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: SANFORD BOKOR **Telephone Number:** (847) 675-3585
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2013 to 12/31/2013 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) MARTIN WEISS
(Title) PRESIDENT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) SANFORD BOKOR, PRESIDENT
(Firm Name & Address) KBKB, LTD., 8140 RIVER DRIVE, MORTON GROVE, IL 60053
(Telephone) (847) 675-3585 Fax # (847) 675-5777

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

Facility Name & ID Number BELLEVILLE HLTHCARE & REHAB # 0034678 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	62	Skilled (SNF)	62	22,630	1
2		Skilled Pediatric (SNF/PED)			2
3	90	Intermediate (ICF)	90	32,850	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	152	TOTALS	152	55,480	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			7,103	7,103	8
9	SNF/PED					9
10	ICF	35,754	1,893	1,288	38,935	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	35,754	1,893	8,391	46,038	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.98%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 09/88

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 09/88 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 62 and days of care provided 7,103

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2013 Fiscal Year: 12/31/2013

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

Facility Name & ID Number BELLEVILLE HLTHCARE & REHAB # 0034678 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	253,495	21,525	10,296	285,316		285,316	7,515	292,831			1
2	Food Purchase		244,838		244,838		244,838		244,838			2
3	Housekeeping	232,915	33,079		265,994		265,994		265,994			3
4	Laundry	61,460	21,092	3,065	85,617		85,617		85,617			4
5	Heat and Other Utilities			134,087	134,087		134,087	78	134,165			5
6	Maintenance	83,781	46,516	19,003	149,300		149,300	167	149,467			6
7	Other (specify):*			41,558	41,558		41,558		41,558			7
8	**TOTAL General Services**	631,651	367,050	208,009	1,206,710		1,206,710	7,760	1,214,470			8
	B. Health Care and Programs											
9	Medical Director			47,333	47,333		47,333		47,333			9
10	Nursing and Medical Records	2,430,438	290,090	9,315	2,729,843		2,729,843	27,939	2,757,782			10
10a	Therapy			19,657	19,657		19,657		19,657			10a
11	Activities	154,030	8,137	1,314	163,481		163,481		163,481			11
12	Social Services	49,555	946	1,314	51,815		51,815		51,815			12
13	CNA Training											13
14	Program Transportation			2,554	2,554		2,554		2,554			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,634,023	299,173	81,487	3,014,683		3,014,683	27,939	3,042,622			16
	C. General Administration											
17	Administrative	93,647		545,000	638,647		638,647	(238,025)	400,622			17
18	Directors Fees											18
19	Professional Services			669,097	669,097		669,097	(413,644)	255,453			19
20	Dues, Fees, Subscriptions & Promotions			61,002	61,002		61,002	(27,885)	33,117			20
21	Clerical & General Office Expenses	166,423	28,789	56,529	251,741		251,741	6,474	258,215			21
22	Employee Benefits & Payroll Taxes			714,963	714,963		714,963		714,963			22
23	Inservice Training & Education			10,877	10,877		10,877	495	11,372			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			19,918	19,918		19,918	5,340	25,258			25
26	Insurance-Prop.Liab.Malpractice			181,432	181,432		181,432	18,470	199,902			26
27	Other (specify):*			376,212	376,212		376,212	(338,315)	37,897			27
28	**TOTAL General Administration**	260,070	28,789	2,635,030	2,923,889		2,923,889	(987,090)	1,936,799			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,525,744	695,012	2,924,526	7,145,282		7,145,282	(951,391)	6,193,891			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#: BELLEVILLE HLTHCARE & REHAB #0034678 **Report Period Beginning: 01/01/2013** **Ending: 12/31/2013**

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	10,296	
	REPAIRS & MAINTENANCE		0	
			0	10,296
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		3,065	
			0	3,065
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		17,625	
	ELECTRICITY		71,203	
	WATER		43,218	
	CABLE TV - LOBBY		2,041	
			0	134,087
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		10,211	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		607	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		0	
	FIRE SERVICE		8,185	
			0	
			0	
			0	
			0	19,003
7	**OTHER**			
	SCAVENGER & EXTERMINATED SERVICE		41,558	
	SECURITY SERVICE		0	
			0	
			0	41,558
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	47,333	47,333

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	2,400	
	PHARMACY CONSULTANT	XVIII B 39-2	6,915	
	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	9,315
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	4,364	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	6,287	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	6,966	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	2,040	
				19,657
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,314	
			0	1,314
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	1,314	
	SOCIAL WORKER	XVIII B 45-2	0	
				1,314
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number BELLEVILLE HLTHCARE & REHAB **#0034678** **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

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

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		2,554	2,554
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	545,000	545,000
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	40,156	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	79,362	
	BOOKKEEPING/ADMINISTRATIVE SERVICE		549,579	669,097
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	26,775	
	EMPLOYEE WANT ADS	XIX F	10,634	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	9,796	
	LICENSES & PERMITS	XIX F	3,006	
	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	5,871	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F		
	PATIENT BACKGROUND CHECKS	XIX F	4,920	
				61,002
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		706	
	EQUIPMENT REPAIR & MAINTENANCE		22,590	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	2,100	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		24,906	
	MESSENGER SERVICE		6,227	
			0	56,529

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	267,415	
	UNEMPLOYMENT COMPENSATION	XIX D	161,946	
	WORKERS COMPENSATION INSURANC	XIX D	161,477	
	HOSPITALIZATION INSURANCE	XIX D	105,861	
	EMPLOYEE BENEFITS - OTHER	XIX D	18,264	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	
			0	714,963
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		10,877	
				10,877
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		19,918	
				19,918
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		181,432	
				181,432
27	**OTHER**			
	BAD DEBTS	VI 24	376,212	
				376,212

GRAND TOTAL COLUMN 3 OTHER **2,924,526**

BELLEVILLE HLTHCARE & REHAB
SCHEDULES
12/31/2013

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

TOTAL FOOD PURCHASE	244,838
LESS SALES TAX	0
NET FOOD	244,838
TOTAL PATIENT CENSUS	46,038
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	138,114
ADD # EMPLOYEE MEALS/DAY	0
TIMES # DAYS	365
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	138,114
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	138,114
NET FOOD	244,838
DIVIDE TOTAL MEALS/YEAR	138,114
COST PER MEAL	1.77
TIMES EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**

HAVE YOU FORGOTTEN TO ENTER SALES TAX ON PAGE 5??

Facility Name & ID Number BELLEVILLE HLTHCARE & REHAB #0034678 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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			54,274	54,274		54,274	165,949	220,223			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			28,621	28,621		28,621	247,920	276,541			32
33	Real Estate Taxes			5,362	5,362		5,362	56,759	62,121			33
34	Rent-Facility & Grounds			480,000	480,000		480,000	(471,454)	8,546			34
35	Rent-Equipment & Vehicles			14,474	14,474		14,474	16,768	31,242			35
36	Other (specify):*							18,962	18,962			36
37	**TOTAL Ownership**			582,731	582,731		582,731	34,904	617,635			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		207,195	1,087,878	1,295,073		1,295,073		1,295,073			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			325,584	325,584		325,584		325,584			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		207,195	1,413,462	1,620,657		1,620,657		1,620,657			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,525,744	902,207	4,920,719	9,348,670		9,348,670	(916,487)	8,432,183			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 BELLEVILLE HLTHCARE & REHAB # 0034678 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	7,415	30		9
10	Interest and Other Investment Income	(76,108)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(2,100)	21		18
19	Entertainment		20		19
20	Contributions	(5,871)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(376,212)	27		24
25	Fund Raising, Advertising and Promotional	(26,775)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(58,263)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (537,914)		$	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)	(378,573)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (378,573)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (916,487)		37

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

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

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

BELLEVILLE HLTHCARE & REHAB

ID# 0034678

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARIES	$ (57,249)	21	1
2	TRANSPORTATION STAFF-MARKETING	(1,014)	25	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(58,263)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BELLEVILLE HLTHCARE & REHAB # 0034678 **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	7,515	0	0	0	0	0	0	0	7,515	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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	78	0	0	0	0	0	0	0	78	5
6	Maintenance	0	0	0	167	0	0	0	0	0	0	0	167	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	7,760	0	0	0	0	0	0	0	7,760	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	27,939	0	0	0	0	0	0	0	27,939	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	27,939	0	0	0	0	0	0	0	27,939	16
	C. General Administration													
17	Administrative	0	0	(238,025)	0	0	0	0	0	0	0	0	(238,025)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	9,325	(298,660)	(124,309)	0	0	0	0	0	0	0	(413,644)	19
20	Fees, Subscriptions & Promotions	(32,646)	0	305	4,456	0	0	0	0	0	0	0	(27,885)	20
21	Clerical & General Office Expenses	(59,349)	0	55,002	10,821	0	0	0	0	0	0	0	6,474	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	495	0	0	0	0	0	0	0	495	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(1,014)	0	2,787	3,567	0	0	0	0	0	0	0	5,340	25
26	Insurance-Prop.Liab.Malpractice	0	15,775	1,752	943	0	0	0	0	0	0	0	18,470	26
27	Other (specify):*	(376,212)	0	28,819	9,078	0	0	0	0	0	0	0	(338,315)	27
28	**TOTAL General Administration**	(469,221)	25,100	(448,020)	(94,949)	0	0	0	0	0	0	0	(987,090)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(469,221)	25,100	(448,020)	(59,250)	0	0	0	0	0	0	0	(951,391)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BELLEVILLE HLTHCARE & REHAB # 0034678 **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	7,415	155,440	2,532	562	0	0	0	0	0	0	0	165,949	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(76,108)	323,891	0	137	0	0	0	0	0	0	0	247,920	32
33	Real Estate Taxes	0	56,264	0	495	0	0	0	0	0	0	0	56,759	33
34	Rent-Facility & Grounds	0	(480,000)	2,737	5,809	0	0	0	0	0	0	0	(471,454)	34
35	Rent-Equipment & Vehicles	0	0	14,997	1,771	0	0	0	0	0	0	0	16,768	35
36	Other (specify):*	0	18,962	0	0	0	0	0	0	0	0	0	18,962	36
37	TOTAL Ownership	(68,693)	74,557	20,266	8,774	0	0	0	0	0	0	0	34,904	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(537,914)	99,657	(427,754)	(50,476)	0	0	0	0	0	0	0	(916,487)	45

Facility Name & ID Number BELLEVILLE HLTHCARE & REHAB # 0034678 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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. [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	34	RENT	$ 480,000	LINCOLN ASSOCIATES, L.P.		$	$ (480,000)	1
2	V	30	DEPRECIATION				155,440	155,440	2
3	V	32	INTEREST EXPENSE				233,946	233,946	3
4	V	32	AMORT LOAN COST				89,945	89,945	4
5	V	33	REAL ESTATE TAXES				56,264	56,264	5
6	V	36	MIP INSURANCE				18,962	18,962	6
7	V	26	INSURANCE				15,775	15,775	7
8	V	19	PROFESSIONAL FEES				9,325	9,325	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 480,000			$ 579,657	$ * 99,657	14

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

Facility Name & ID Number BELLEVILLE HLTHCARE & REHAB # 0034678 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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)	
15	V	17	MANAGEMENT FEES	$ 545,000	WEISS MANAGEMENT GROUP, INC.		$	$ (545,000)	15
16	V	19	ADMIN./BKKP. FEES	300,000				(300,000)	16
17	V								17
18	V								18
19	V	17	ADMINISTRATIVE SALARIES				306,975	306,975	19
20	V	19	PROFESSIONAL FEES				1,340	1,340	20
21	V	20	LICENSES & PERMITS				305	305	21
22	V	21	OFFICE EXPENSES				55,002	55,002	22
23	V	25	TRANSPORTATION STAFF				2,787	2,787	23
24	V	26	INSURANCE				1,752	1,752	24
25	V	27	EMPLOYEE BENEFITS				28,819	28,819	25
26	V	30	DEPRECIATION (SL)				2,532	2,532	26
27	V	34	OFFICE RENT				2,737	2,737	27
28	V	35	AUTO LEASE				14,997	14,997	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 845,000			$ 417,246	$ * (427,754)	39

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

Facility Name & ID Number BELLEVILLE HLTHCARE & REHAB # 0034678 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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)	
15	V	19	BKKPNG/ADMIN SERVICES	$ 162,200	BRIA HEALTH SERVICES, LLC		$	$ (162,200)	15
16	V								16
17	V								17
18	V								18
19	V	1	DIETARY SALARIES				7,515	7,515	19
20	V	5	UTILITIES				78	78	20
21	V	6	REPAIR/MAINT				167	167	21
22	V	10	NURSING SALARIES				27,939	27,939	22
23	V	19	PROFESSIONAL FEES				37,891	37,891	23
24	V	20	WANT ADS, LICENSES				4,456	4,456	24
25	V	21	TOTAL OFFICE				10,821	10,821	25
26	V	23	SEMINARS				495	495	26
27	V	25	TRANSPORTATIONAL STAFF				3,567	3,567	27
28	V	26	INSURANCE				943	943	28
29	V	27	EMPLOYEE BENEFITS				9,078	9,078	29
30	V	30	DEPRECIATION (SL)				562	562	30
31	V	32	INTEREST				137	137	31
32	V	33	RE TAX				495	495	32
33	V	34	OFFICE RENT				5,809	5,809	33
34	V	35	EQUIPMENT RENTAL				1,771	1,771	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 162,200			$ 111,724	$ * (50,476)	39

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

Facility Name & ID Number BELLEVILLE HLTHCARE & REHAB # 0034678 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2	MARTIN J. WEISS	45.10	ATRIUM H.C. & REHAB CENTER OF		WEISS MGMT	LINCOLNWOOD	MANAGEMENT/	2
3	DANIEL WEISS	12.31	CAHOKIA, LLC	CAHOKIA	GROUP, INC		CLERICAL	3
4	GARY WEINTRAUB	14.45						4
5	ILANA FINN	4.69	GENEVA NURSING & REHAB CENTER	GENEVA	BRIA HEALTH	LINCOLNWOOD	MANAGEMENT	5
6	CATHLENE WEISS	5.88			SERVICES, LLC		SERVICES	6
7	SUZANNE KOENIG	9.18	MST HEALTH CARE PROPERTIES	SOUTH CHICAGO				7
8	NATAN WEISS	8.39		HEIGHTS	LINCOLN ASSO-	LINCOLNWOOD	REAL ESTATE	8
9					CIATES, L.P.			9
10			LAKE PARK CENTER	WAUKEGAN				10
11								11
12			WESTMONT NURSING & REHAB					12
13			CENTER, LLC	WESTMONT				13
14								14
15			FOREST EDGE HEALTHCARE REHAB					15
16			CENTER	CHICAGO				16
17								17
18			RIVER OAKS HEALTHCARE REHAB					18
19			CENTER	BURNHAM				19
20								20
21			PALOS HILLS HEALTHCARE, LLC	PALOS HILLS				21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number BELLEVILLE HLTHCARE & REHAB # 0034678 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	ALLOCATIONS FROM WEISS MANAGEMENT GROUP:								$		1
2	MARTIN WEISS	PRESIDENT	ADMINISTRATIO	45.10	SEE	10	22.22	SALARY	102,325	17-7	2
3					ATTACHED						3
4	DANIEL WEISS	MANAGER	MANAGEMENT	12.31	SCHEDULE	15	13.04	SALARY	102,325	17-7	4
5											5
6	NATAN WEISS	CFO	FINANCE/MGMT	8.39		10	13.51	SALARY	102,235	17-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 306,885		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 BELLEVILLE HLTHCARE & REHAB # 0034678 Report Period Beginning: 01/01/2013 Ending: 2/31/2013

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: WEISS MANAGEMENT GROUP, INC
Street Address: 6865 N LINCOLN AVE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-5794
Fax Number: (847) 674-5794

	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	17	ADMINISTRATIVE SALARIES	PATIENT CENSUS	89,984	2	$ 600,000	$ 600,000	46,038	$ 306,975	1
2	19	PROFESSIONAL FEES	PATIENT CENSUS	89,984	2	2,619		46,038	1,340	2
3	20	LICENSES & PERMITS	PATIENT CENSUS	89,984	2	596		46,038	305	3
4	21	OFFICE EXPENSES	PATIENT CENSUS	89,984	2	107,505		46,038	55,002	4
5	25	TRANSPORTATION STAFF	PATIENT CENSUS	89,984	2	5,448		46,038	2,787	5
6	26	INSURANCE	PATIENT CENSUS	89,984	2	3,425		46,038	1,752	6
7	27	EMPLOYEE BENEFITS	PATIENT CENSUS	89,984	2	56,329		46,038	28,819	7
8	30	DEPRECIATION (SL)	PATIENT CENSUS	89,984	2	4,949		46,038	2,532	8
9	34	OFFICE RENT	PATIENT CENSUS	89,984	2	5,350		46,038	2,737	9
10	35	AUTO LEASE	PATIENT CENSUS	89,984	2	29,312		46,038	14,997	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					$ 815,533	$ 600,000		$ 417,246	25

Facility Name & ID Number BELLEVILLE HLTHCARE & REHAB # 0034678 Report Period Beginning: 01/01/2013 Ending: 2/31/2013

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: BRIA HEALTH SERVICES, LLC
Street Address: 6865 N LINCOLN AVE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	PATIENT CENSUS	475,523	8	$ 77,622	$ 77,622	46,038	$ 7,515	1
2	5	UTILITIES	PATIENT CENSUS	475,523	8	806		46,038	78	2
3	6	REPAIR/MAINT	PATIENT CENSUS	475,523	8	1,722		46,038	167	3
4	10	NURSING SALARIES	PATIENT CENSUS	475,523	8	288,582	288,582	46,038	27,939	4
5	19	PROFESSIONAL FEES	PATIENT CENSUS	475,523	8	391,370	100,000	46,038	37,891	5
6	20	WANT ADS, LICENSES	PATIENT CENSUS	475,523	8	46,030		46,038	4,456	6
7	21	TOTAL OFFICE	PATIENT CENSUS	475,523	8	111,765	36,036	46,038	10,821	7
8	23	SEMINARS	PATIENT CENSUS	475,523	8	5,110		46,038	495	8
9	25	TRANSPORTATIONAL STAFF	PATIENT CENSUS	475,523	8	36,847		46,038	3,567	9
10	26	INSURANCE	PATIENT CENSUS	475,523	8	9,739		46,038	943	10
11	27	EMPLOYEE BENEFITS	PATIENT CENSUS	475,523	8	93,769		46,038	9,078	11
12	30	DEPRECIATION (SL)	PATIENT CENSUS	475,523	8	5,805		46,038	562	12
13	32	INTEREST	PATIENT CENSUS	475,523	8	1,420		46,038	137	13
14	33	RE TAX	PATIENT CENSUS	475,523	8	5,109		46,038	495	14
15	34	OFFICE RENT	PATIENT CENSUS	475,523	8	60,000		46,038	5,809	15
16	35	EQUIPMENT RENTAL	PATIENT CENSUS	475,523	8	18,286		46,038	1,771	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,153,982	$ 502,240		$ 111,724	25

Facility Name & ID Number BELLEVILLE HLTHCARE & REHAB # 0034678 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	RELATED PARTY: THE LINCOLN ASSOCIATION, LLC						$	$			$	1
2	BEECH STREET CAPITAL		X	MORTGAGE	$33,868.29	09/01/13	4,528,900	4,494,282	04/01/39	3.8700	233,946	2
3	AMORT LOAN COST		X	AMORT OVER LIFE			84,735	83,635			89,945	3
4												4
5												5
	Working Capital											
6	BANK FINANCIAL	X		WORKING CAPITAL	DEMAND			1,100,430		PRIME+	25,935	6
7		X		INSURANCE FINANCING							2,686	7
8	RELATED PARTY ALLOCATION										137	8
9	TOTAL Facility Related				$33,868.29		$ 4,613,635	$ 5,678,347			$ 352,649	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 4,613,635	$ 5,678,347			$ 352,649	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 18,962 **Line #** 36

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

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

Facility Name & ID Number BELLEVILLE HLTHCARE & REHAB # 0034678 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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.**	$ 56,699	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.)		$ 61,563	2
3. Under or (over) accrual (line 2 minus line 1).		$ 4,864	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 56,762	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.		$ 61,626	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	51,185	8
	2009	53,890	9
	2010	59,552	10
	2011	61,492	11
	2012	61,563	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2012 TAX BILL.

	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 BELLEVILLE HLTHCARE & REHAB COUNTY ST CLAIR

FACILITY IDPH LICENSE NUMBER 0034678

CONTACT PERSON REGARDING THIS REPORT SANFORD BOKOR

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

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

Enter the tax index number and real estate tax assessed for 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.	08-20.0-204-015	NURSING HOME	$ 2,999.98	$ 2,999.98
2.	08-20.0-210-029	NURSING HOME	$ 54,809.86	$ 54,809.86
3.	08-20.0-207-025	NURSING HOME	$ 1,144.36	$ 1,144.36
4.	08-20.0-210-028	NURSING HOME	$ 246.82	$ 246.82
5.	08-20.0-204-014	NURSING HOME	$ 2,361.92	$ 2,361.92
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 61,562.94	$ 61,562.94

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 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 BELLEVILLE HLTHCARE & REHAB # 0034678 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,241 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 2

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).

N/A

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

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

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	3+ACRES	1987	$ 148,649	1
2	PARKING LOT	2+ACRES	2005	50,000	2
3	TOTALS	#VALUE!		$ 198,649	3

Facility Name & ID Number BELLEVILLE HLTHCARE & REHAB # 0034678 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	152		1988		$ 2,011,351	$ 63,852	31.5	$ 63,852	$	$ 1,589,393	4
5			2003		1,249,221	45,426	27.5	45,426		475,080	5
6											6
7											7
8	RELATED PARTY ALLOCATION					409		409			8
	Improvement Type**										
9	VARIOUS			1990	11,158	354	31.5	354		8,236	9
10	VARIOUS			1993	6,676	171	39	171		4,292	10
11	VARIOUS			1994	7,797	200	39	200		4,858	11
12	VARIOUS			1995	13,072	335	39	335		7,262	12
13	CARPET			1996	907	23	39	23		443	13
14	BILLBOARD			1996	900	23	39	23		446	14
15	SMOKE DETECTORS			1996	602	15	39	15		295	15
16	PARKING LOT			1996	8,006	205	39	205		4,075	16
17	AWNING			1996	905	23	39	23		461	17
18	CARPETING			1996	1,512	39	39	39		794	18
19	DOOR LOCKS			1997	2,100	54	39	54		976	19
20	WALL PAPER			1997	2,012	52	39	52		950	20
21	HANDRAIL			1997	3,217	83	39	83		1,440	21
22	FIRE ALARM SYSTEM			1998	11,636	298	39	298		4,761	22
23	WALLPAPER & HANDRAILS FOR NURSING STATION			1998	9,227	236	39	236		3,777	23
24	PAINTING/WALLPAPERING			1998	2,988	77	39	77		1,230	24
25	REPLACE PVC PIPE IN BASEMENT			1998	1,074	28	39	28		447	25
26	WALLPAPER, HANDRAILS, CRASHRAILS, CORNER GUARD			1999	6,144	158	39	158		1,980	26
27	INSTALLED A NEW DURO-LAST ROOF			1999	56,400	1,446	39	1,446		18,070	27
28	WALLPAPER			2000	14,896	382	39	382		5,711	28
29	SEWER LINE REPAIR			2000	11,743	301	39	301		4,057	29
30	AIR CONDITIONING UNITS			2000	8,848	227	39	227		3,059	30
31	CONDENSING UNIT ON FREEZER			2000	2,693	69	39	69		933	31
32	NEW NURSES STATION			2000	20,379	522	39	522		7,057	32
33	FIRE ALARM SYSTEM			2000	1,826	47	39	47		635	33
34	HOT WATER SYSTEM			2000	3,849	99	20	99		2,351	34
35	TILED FLOORS			2000	54,185	1,389	39	1,389		18,761	35
36	REMODELOING OF BATHROOMS			2000	18,490	474	39	474		6,397	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 BELLEVILLE HLTHCARE & REHAB # 0034678 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	INSTALLED A/C UNITS FOR RESIDENT ROOMS	2000	$ 13,369	$	20	$ 668	$ 668	$ 11,342	37
38	WALLPAPERING, FLOORING,CARPENTING	2001	35,921	1,306	27.5	1,306		16,326	38
39	ROOF	2001	47,500	1,727	27.5	1,727		21,588	39
40	AIR CONDITIONERS,HEATERS, SPEAKERS	2001	9,154	334	27.5	334		4,174	40
41	ELECTRICAL WORK	2001	12,200	444	27.5	444		5,550	41
42	RECEPTION STATION	2001	11,356	413	27.5	413		5,162	42
43	WINDOW TREATMENTS, CUBICLE TRACK,DOORS	2001	54,533	1,983	27.5	1,983		24,787	43
44	EXTENSIVE WORK	2001	37,603	1,366	27.5	1,366		17,076	44
45	RESIDENT ROOMS-PAINTING, CLOSET, CORRID. DOORS	2002	31,159		20	1,558	1,558	18,696	45
46	RENOVATIONS TO THE SHOWER & STORAGE ROOM	2002	6,853	249	27.5	249		2,916	46
47	INSTALLATION OF THE NEW GENERATOR SET CONTROL	2002	17,036	619	27.5	619		7,248	47
48	INSTALL STEP RAILS FOR SIDEWALK AREA, FRONT ENTR	2002	7,245	263	27.5	263		3,079	48
49	LANDSCAPING	2004	7,759		15	517	517	4,847	49
50	REPLACEMENT WINDOWS	2004	32,853		20	1,643	1,643	16,430	50
51	INSTALL CONCRETE DUMSTER PAD AND DRIVE	2004	6,270		20	314	314	3,140	51
52	REMODELING SHOWER ROOM-FLOOR &WALL CERAMIC	2004	105,250		20	5,263	5,263	52,630	52
53	WALL AIR CONDITIONS	2005	3,190	116	27.5	116		981	53
54	FLOORING, WALLCOVERING-2 RESTROOMS	2005	2,528	92	27.5	92		778	54
55	FURNISH AND INSTALL FIRE RATED DOORS & FRAMES	2005	30,429	1,106	27.5	1,106		9,356	55
56	EXCAVATING AND POURING CONCRETE SIDEWALKS	2005	9,450	344	27.5	344		2,909	56
57	INSTALL RAILS, REPLACEMENT WINDOWS	2005	8,406	306	27.5	306		2,588	57
58	INSTALL ALARM SYSTEM	2005	39,496	1,436	27.5	1,436		12,146	58
59	NURSE CALL SYSTEM	2005	18,665	679	27.5	679		5,743	59
60	LOBBY AREA, VESTIBULE-FLOORING	2006	17,906		5			17,906	60
61	AIR CONDITIONERS	2007	7,968		5			7,968	61
62	RESIDENT ROOMS - HINGET DOORS-NO CROWN	2007	57,309	2,084	27.5	2,084		13,459	62
63	PARKING LOT AND FENCE	2007	5,125	342	15	342		2,137	63
64	REPLACED 3 COMPRESSORS IN RTU'S	2007	3,914	142	27.5	142		917	64
65	PAINTING	2007	9,986		5			9,986	65
66	GARDEN	2007	60,172	2,188	15	4,012	1,824	23,980	66
67	ROOF REPLACEMENT-ACTIVITY CENTER	2008	5,400	196	27.5	196		1,086	67
68	PAINTING - 30 ROOMS	2008	2,550	146	5	146		2,550	68
69	CONFERENCE ROOM-INSTALLATION OF CERAMIC TILE	2008	2,877	105	27.5	105		608	69
70	TOTAL (lines 4 thru 69)		$ 4,265,246	$ 135,003		$ 146,790	$ 11,787	$ 2,508,316	70

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

Facility Name & ID Number BELLEVILLE HLTHCARE & REHAB # 0034678 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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		$ 4,265,246	$ 135,003		$ 146,790	$ 11,787	$ 2,508,316	1
2	GRADING PARKING LOT	2008	1,473	98	15	98		564	2
3	DOOR GUARDS - VARIOUS DIFFERENT AREAS	2008	4,672	170	27.5	170		956	3
4	WALL AIR CONDITIONS	2009	5,187	598	5	598		4,889	4
5	INSTALL NEW COMPRESSOR,CRANK CASE HEATER	2009	3,195	116	27.5	116		537	5
6	INSTALL SIDEWALL EXHAUST DUST FAN	2009	8,048	293	27.5	293		1,331	6
7	CERAMIC TILE, HANDRAILS, CUSTOM NURSING STATION	2009	114,376	4,159	27.5	4,159		19,235	7
8	WALLCOVERING, CARPET, PAINTING, BLINDS, CURTAINS	2009	29,344	3,380	5	3,380		27,653	8
9	WALL AIR CONDITIONS	2010	4,581	264	5	264		4,186	9
10	INSTALL STEEL DOOR	2010	10,694	389	27.5	389		1,313	10
11	FIRE PROTECTION WORK-SPRINKLERS PHASE 1	2010	97,653	3,551	27.5	3,551		11,097	11
12	FIRE PROTECTION WORK-SPRINKLERS PHASE 2	2011	97,652	3,551	27.5	3,551		7,546	12
13	WING CORRIDORS-FLOORING,WALLCOVERING,	2011	67,587	2,458	27.5	2,458		7,272	13
14	HANDRAILS,BUNPER GUARDS,SIGNAGE,WALL PROTECTION								14
15	INSTALL NEW CARRIER RTU	2011	4,517	164	27.5	164		417	15
16	PAINTING-100 & 200 HALL, LODGING, NURSES STATION	2011	44,405	10,124	5	10,124		29,218	16
17	WALL AIR CONDITIONS	2011	7,698		5	1,540	1,540	4,620	17
18	WALL AIR CONDITIONS	2012	4,194	545	5	545		3,376	18
19	REPLACED ROOF TOP UNIT & 5 TON CONDENSING UNIT	2012	9,995	363	27.5	363		529	19
20	INSTALL NEW PLASTIC CEMENT, CAP,COTTON MEMBRA-								20
21	NE ON EPDM ROOF	2012	2,595	94	27.5	94		176	21
22	PARKING LOT IMPROVMENTS; CONCRETE PATIO AND								22
23	DRAINAGE	2012	72,786	4,852	15	4,852		5,256	23
24	INSTALLED A 240CFM EXHAUST FAN ON A CURB OVER								24
25	THE NURSES STATION	2013	3,044	106	27.5	106		106	25
26	LOBBY; OFFICES-CARPET INSTALLATION; WALL BASE								26
27	INSTALLATION	2013	7,824	202	27.5	202		202	27
28	SEAL COAT PARKING LOT AND STRIPE PARKING SPACES	2013	3,000	133	15	133		133	28
29	100, 200, 300, 400 WINGS- CORRIDOR, RESIDENT ROOMS,								29
30	RESIDENT BATHSROOMS-FLOORING	2013	164,523	249	27.5	249		249	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,034,289	$ 170,862		$ 184,189	$ 13,327	$ 2,639,177	34

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

Facility Name & ID Number BELLEVILLE HLTHCARE & REHAB # 0034678 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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		$ 5,034,289	$ 170,862		$ 184,189	$ 13,327	$ 2,639,177	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,034,289	$ 170,862		$ 184,189	$ 13,327	$ 2,639,177	34

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

Facility Name & ID Number BELLEVILLE HLTHCARE & REHAB # 0034678 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	$ 310,988	$ 29,294	$ 31,100	$ 1,806	3-10	$ 131,136	71
72	Current Year Purchases	14,693	8,816	1,098	(7,718)	5-8	1,098	72
73	Fully Depreciated Assets	111,406					111,406	73
74	RELATED PARTY SL DEPRECIATION		3,836	3,836				74
75	TOTALS	$ 437,087	$ 41,946	$ 36,034	$ (5,912)		$ 243,640	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	2005 FORD ECONOCARE	2005	$ 41,500	$	$	$		$ 41,500	76
77										77
78										78
79										79
80	TOTALS			$ 41,500	$	$	$		$ 41,500	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)	$ 5,711,525	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 212,808	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 220,223	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 7,415	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,924,317	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number BELLEVILLE HLTHCARE & REHAB # 0034678 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							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.		$
13.		$
14.		$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 14,474 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			N/A		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 BELLEVILLE HLTHCARE & REHAB # 0034678 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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

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

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

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

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number BELLEVILLE HLTHCARE & REHAB # 0034678 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	39-3	hrs	$		$ 447,424	$		$ 447,424	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			131,827			131,827	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			508,627			508,627	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				161,481		161,481	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): RADIOLOGY, LAB	39-2					18,296		18,296	12
13	MEDICAL SUPPLY Other (specify): I.V. THERAPT	39-2					27,418		27,418	13
14	TOTAL			$		$ 1,087,878	$ 207,195		$ 1,295,073	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 BELLEVILLE HLTHCARE & REHAB # 0034678 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2013 (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	$ 461,362	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 200,000)	2,979,655		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	178,983		6
7	Other Prepaid Expenses	59,748		7
8	Accounts Receivable (owners or related parties)	150,000		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,829,748	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	172,026		13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	158,256		15
16	Equipment, at Historical Cost	478,587		16
17	Accumulated Depreciation (book methods)	(517,907)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 290,962	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,120,710	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,103,973	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,100,430		29
30	Accrued Salaries Payable	226,687		30
31	Accrued Taxes Payable (excluding real estate taxes)	31,870		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,462,960	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	DUE TO LINCOLN ASSOCIATES	324,749		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 324,749	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,787,709	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,333,001	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,120,710	$	48

***(See instructions.)**

Facility Name & ID Number BELLEVILLE HLTHCARE & REHAB # 0034678 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,418,484	1	
2	Restatements (describe):		2	
3	REPLACEMENT TAX	(8,382)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,410,102	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	57,899	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	(135,000)	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)**	$ (77,101)	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)**	$ 1,333,001	24	*

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

Facility Name & ID Number BELLEVILLE HLTHCARE & REHAB # 0034678 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	$ 9,330,461	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,330,461	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***	76,108	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 76,108	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)**	$ 9,406,569	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,206,710	31
32	Health Care	3,014,683	32
33	General Administration	2,923,889	33
	B. Capital Expense		
34	Ownership	582,731	34
	C. Ancillary Expense		
35	Special Cost Centers	1,295,073	35
36	Provider Participation Fee	325,584	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,348,670	40
41	**Income before Income Taxes (line 30 minus line 40)****	57,899	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 57,899	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,176,859	44
45	Private Pay - Net Inpatient Revenue	325,226	45
46	Medicare - Net Inpatient Revenue	3,846,273	46
47	Other-(specify) HOSPICE	505,643	47
48	Other-(specify) MANAGED CARE	476,460	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 9,330,461	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

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

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

Facility Name & ID Number BELLEVILLE HLTHCARE & REHAB # 0034678 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	1,612	1,620	$ 66,157	$ 40.84	1
2	Assistant Director of Nursing	1,912	1,992	74,464	37.38	2
3	Registered Nurses	11,451	12,049	303,827	25.22	3
4	Licensed Practical Nurses	33,718	35,134	704,118	20.04	4
5	CNAs & Orderlies	100,707	105,623	1,121,374	10.62	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	15,029	15,408	154,030	10.00	10
11	Social Service Workers	3,610	3,762	49,555	13.17	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	25,684	27,132	253,495	9.34	15
16	Dishwashers					16
17	Maintenance Workers	5,567	5,811	83,781	14.42	17
18	Housekeepers	24,204	24,959	232,915	9.33	18
19	Laundry	6,816	7,109	61,460	8.65	19
20	Administrator	1,936	2,080	93,647	45.02	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,877	12,370	166,423	13.45	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	5,369	5,681	68,331	12.03	31
32	Other Health C: Care Plan Coord	3,949	4,232	92,167	21.78	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	253,441	264,962	$ 3,525,744 *	$ 13.31	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	M	$ 10,296	1-3	35
36	Medical Director	O	47,333	9-3	36
37	Medical Records Consultant	N	2,400	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	6,915	10-3	39
40	Physical Therapy Consultant	L	4,364	10a-3	40
41	Occupational Therapy Consultant	Y	6,287	10a-3	41
42	Respiratory Therapy Consultant		6,966	10a-3	42
43	Speech Therapy Consultant	F	2,040	10a-3	43
44	Activity Consultant	E	1,314	11-3	44
45	Social Service Consultant	E	1,314	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 89,229		49

C. CONTRACT NURSES

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

Facility Name & ID Number BELLEVILLE HLTHCARE & REHAB # 0034678 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
KENYA WASHINGTON	ADMINISTRATOR	0	$ 93,647
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 93,647

B. Administrative - Other

Description		Amount
WEISS MANAGEMENR GROUP	MANAGEMENT FEES	$ 545,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)		$ 545,000

C. Professional Services

Vendor/Payee	Type	Amount
SEE SCHEDULE ATTACHED		669,097
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 669,097

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 161,477
Unemployment Compensation Insurance	161,946
FICA Taxes	267,415
Employee Health Insurance	105,861
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	18,264
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	0
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 714,963

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

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	10,634
Health Care Worker Background Check	0
(Indicate # of checks performed)	
Patient Background Checks 492	4,920
TRUST/FRANCHISE/CONTRIB/ETC	5,871
MARKETING/ADV/PROMO	26,775
LICENSES/DUES/SUBSCRIPTIONS	10,812
MGMT CO ALLOC	4,761
TRUST/FRANCHISE/CONTRIB/ETC	(5,871)
Less: Public Relations Expense	(0)
Non-allowable advertising	(26,775)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 33,117

G. Schedule of Travel and Seminar**

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

**See instructions.

Facility Name & ID Number BELLEVILLE HLTHCARE & REHAB # 0034678 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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													
4													
5													
6													
7							N/A						
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number BELLEVILLE HLTHCARE & REHAB # 0034678 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL ON LONG TERM CARE $ 9,571**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

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

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **31,069** 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. $ **325,584**
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. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name:

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

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