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: 0024968

Facility Name: BELMONT NURSING HOME

Address: 1936 W BELMONT AVE (Number) CHICAGO (City) 60657 (Zip Code)

County: COOK

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

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: 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 07/01/2012 to 06/30/2013 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) EILEEN CONWAY
(Title) PRESIDENT

Paid Preparer

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

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

Facility Name & ID Number BELMONT NURSING HOME # 0024968 Report Period Beginning: 07/01/2012 Ending: 06/30/2013

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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	61	Intermediate (ICF)	61	22,265	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	61	TOTALS	61	22,265	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	18,113			18,113	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,113			18,113	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.35%

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

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

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

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

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

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

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

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

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

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

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 BELMONT NURSING HOME # 0024968 Report Period Beginning: 07/01/2012 Ending: 06/30/2013

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	138,587	31,662	2,736	172,985		172,985		172,985			1
2	Food Purchase		119,858		119,858	(4,599)	115,259	(1,113)	114,146			2
3	Housekeeping	54,690	46,789		101,479		101,479		101,479			3
4	Laundry											4
5	Heat and Other Utilities			36,084	36,084		36,084		36,084			5
6	Maintenance	64,448	37,806	937	103,191		103,191		103,191			6
7	Other (specify):*			9,480	9,480		9,480		9,480			7
8	TOTAL General Services	257,725	236,115	49,237	543,077	(4,599)	538,478	(1,113)	537,365			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	606,025	20,947	2,901	629,873		629,873		629,873			10
10a	Therapy											10a
11	Activities	21,450	10,344		31,794		31,794		31,794			11
12	Social Services			4,683	4,683		4,683		4,683			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	627,475	31,291	7,584	666,350		666,350		666,350			16
	C. General Administration											
17	Administrative	250,475			250,475		250,475		250,475			17
18	Directors Fees											18
19	Professional Services			45,378	45,378		45,378		45,378			19
20	Dues, Fees, Subscriptions & Promotions			17,373	17,373		17,373	(3,500)	13,873			20
21	Clerical & General Office Expenses	38,350	35,818	2,721	76,889		76,889		76,889			21
22	Employee Benefits & Payroll Taxes			236,587	236,587	4,599	241,186		241,186			22
23	Inservice Training & Education			815	815		815		815			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			658	658		658		658			25
26	Insurance-Prop.Liab.Malpractice			33,338	33,338		33,338		33,338			26
27	Other (specify):*											27
28	TOTAL General Administration	288,825	35,818	336,870	661,513	4,599	666,112	(3,500)	662,612			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,174,025	303,224	393,691	1,870,940		1,870,940	(4,613)	1,866,327			29

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

Facility Name & ID#: BELMONT NURSING HOME **#0024968** **Report Period Beginning: 07/01/2012** **Ending: 06/30/2013**

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	2,736	
	REPAIRS & MAINTENANCE		0	
			0	2,736
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		0	
	ELECTRICITY		0	
	WATER		0	
	CABLE TV - LOBBY		1,030	
	UTILITIES		35,054	36,084
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		0	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		0	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		937	
	FIRE SERVICE		0	
			0	
			0	
			0	
			0	937
7	**OTHER**			
	SCAVENGER		9,480	
	SECURITY SERVICE		0	
			0	
			0	9,480
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	0	0

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	630	
	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	0	
	PHARMACY CONSULTANT	XVIII B 39-2	2,271	
	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	2,901
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	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
			0	0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	4,683	
				4,683
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number BELMONT NURSING HOME **#0024968** **Report Period Beginning:** 07/01/2012 **Ending:** 06/30/2013

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

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	0	0
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	899	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	44,479	
			0	45,378
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	0	
	EMPLOYEE WANT ADS	XIX F	0	
	CONTRIBUTIONS	VI 20 XIX F	3,500	
	DUES & SUBSCRIPTIONS	XIX F	8,693	
	LICENSES & PERMITS	XIX F	4,350	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	830	
	PATIENT BACKGROUND CHECKS	XIX F	0	
				17,373
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		0	
	EQUIPMENT REPAIR & MAINTENANCE		0	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		2,721	
	MESSENGER SERVICE		0	
			0	2,721

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	84,202	
	UNEMPLOYMENT COMPENSATION	XIX D	5,735	
	WORKERS COMPENSATION INSURANC	XIX D	20,900	
	HOSPITALIZATION INSURANCE	XIX D	84,994	
	EMPLOYEE BENEFITS - OTHER	XIX D	3,351	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	37,405	
	CHICAGO HEAD TAX	XIX D	0	
			0	236,587
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		815	
				815
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		658	
				658
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		33,338	
				33,338
27	**OTHER**			
	BAD DEBTS	VI 24	0	
				0

GRAND TOTAL COLUMN 3 OTHER **393,691**

BELMONT NURSING HOME
SCHEDULES
06/30/2013

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

TOTAL FOOD PURCHASE	119,858
LESS SALES TAX	(1,113)
NET FOOD	118,745
TOTAL PATIENT CENSUS	18,113
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	54,339
ADD # EMPLOYEE MEALS/DAY	6
TIMES # DAYS	365
TOTAL EMPLOYEE MEALS	2,190
PATIENT MEALS	54,339
ADD EMPLOYEE MEALS	2,190
TOTAL MEALS/YEAR	56,529
NET FOOD	118,745
DIVIDE TOTAL MEALS/YEAR	56,529
COST PER MEAL	2.10
TIMES EMPLOYEE MEALS	2,190
EMPLOYEE MEAL RECLASSIFICATION	**4,599**

Facility Name & ID Number BELMONT NURSING HOME #0024968 Report Period Beginning: 07/01/2012 Ending: 06/30/2013

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							57,403	57,403			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			30,765	30,765		30,765	(34,986)	(4,221)			32
33	Real Estate Taxes			40,830	40,830		40,830		40,830			33
34	Rent-Facility & Grounds			305,176	305,176		305,176		305,176			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			376,771	376,771		376,771	22,417	399,188			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			171,969	171,969		171,969		171,969			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			171,969	171,969		171,969		171,969			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,174,025	303,224	942,431	2,419,680		2,419,680	17,804	2,437,484			45

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

Facility Name & ID Number BELMONT NURSING HOME # 0024968 Report Period Beginning: 07/01/2012 Ending: 06/30/2013

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	57,403	30		9
10	Interest and Other Investment Income	(34,986)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,113)	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		21		18
19	Entertainment		20		19
20	Contributions	(3,500)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional		20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		10		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 17,804		$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 17,804		37

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

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

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

BELMONT NURSING HOME

ID# 0024968

Report Period Beginning: 07/01/2012

Ending: 06/30/2013

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

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BELMONT NURSING HOME # 0024968 **Report Period Beginning:** 07/01/2012 **Ending:** 06/30/2013

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,113)	0	0	0	0	0	0	0	0	0	0	(1,113)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,113)	0	0	0	0	0	0	0	0	0	0	(1,113)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(3,500)	0	0	0	0	0	0	0	0	0	0	(3,500)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(3,500)	0	0	0	0	0	0	0	0	0	0	(3,500)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(4,613)	0	0	0	0	0	0	0	0	0	0	(4,613)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BELMONT NURSING HOME # 0024968 **Report Period Beginning:** 07/01/2012 **Ending:** 06/30/2013

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	57,403	0	0	0	0	0	0	0	0	0	0	57,403	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(34,986)	0	0	0	0	0	0	0	0	0	0	(34,986)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	22,417	0	0	0	0	0	0	0	0	0	0	22,417	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)**	17,804	0	0	0	0	0	0	0	0	0	0	17,804	45

Facility Name & ID Number BELMONT NURSING HOME # 0024968 Report Period Beginning: 07/01/2012 Ending: 06/30/2013

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
EILEEN CONWAY	100					

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

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

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

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

Facility Name & ID Number BELMONT NURSING HOME # 0024968 Report Period Beginning: 07/01/2012 Ending: 06/30/2013

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								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

Facility Name & ID Number BELMONT NURSING HOME # 0024968 Report Period Beginning: 07/01/2012 Ending: 06/30/2013

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	EILEEN CONWAY	PRESIDENT	FINANCE	100.00		40	100.00	SALARY	$ 150,000	17-1	1
2			BANKING								2
3			PATIENT RELATIONS								3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 150,000		13

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

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

Facility Name & ID Number BELMONT NURSING HOME # 0024968 Report Period Beginning: 07/01/2012 Ending: 6/30/2013

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 [ ] NO [X]

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

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

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

Facility Name & ID Number BELMONT NURSING HOME # 0024968 Report Period Beginning: 07/01/2012 Ending: 06/30/2013

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							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	COMMUNITY BANK		X	LINE OF CREDIT	INT ONLY		100,000	75,000	REVOLV	PRIME +	1,371	6
7	SHAREHOLDER LOAN			WORKING CAPITAL	$6,712.94	2/2/09	530,250	255,887	2/17/17	5.0000	19,964	7
8	INLAND BANK		X	WORKING CAPITAL	$2,200.00	10/19/05		131,494	10/19/17	6.5000	9,430	8
9	TOTAL Facility Related				$8,912.94		$ 630,250	$ 462,381			$ 30,765	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 630,250	$ 462,381			$ 30,765	15

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

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

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

Facility Name & ID Number BELMONT NURSING HOME # 0024968 Report Period Beginning: 07/01/2012 Ending: 06/30/2013

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.**	$ 49,707	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.)		$ 49,593	2
3. Under or (over) accrual (line 2 minus line 1).		$ (114)	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 55,897	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.)**		$ 7,503	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** $ 22,456 **For** 08, 09 **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$ (22,456)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 40,830	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	68,040	8
	2009	48,593	9
	2010	49,915	10
	2011	49,707	11
	2012	55,490	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 100% OF THE PRIOR YEAR REAL ESTATE TAX BILL.
THE PAYMENT ON LINE 2 APPLIES TO THE 2ND INSTALL OF 2011 TAX BILL AND 1ST INSTALMENT OF 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 BELMONT NURSING HOME COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0024968

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.	14-19-432-030-0000	NURSING HOME	$ 11,461.38	$ 11,461.38
2.	14-19-432-031-0000	NURSING HOME	$ 14,774.70	$ 14,774.70
3.	14-19-432-032-0000	NURSING HOME	$ 29,254.41	$ 29,254.41
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 55,490.49	$ 55,490.49

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 BELMONT NURSING HOME # 0024968 Report Period Beginning: 07/01/2012 Ending: 06/30/2013

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

Facility Name & ID Number BELMONT NURSING HOME # 0024968 Report Period Beginning: 07/01/2012 Ending: 06/30/2013

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			1979	1919	$ 138,750	$		$	$	$ 138,750	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS			84	9,518		20			9,518	9
10	VARIOUS			88	4,145		20			4,145	10
11	VARIOUS			89	5,009		20			5,009	11
12	VARIOUS			83	5,000		20			5,000	12
13	VARIOUS			84	1,300		20			1,300	13
14	VARIOUS			82	5,000		20			5,000	14
15	ADDITIONS			93	72,104		20	1,826	1,826	72,104	15
16	RADIATOR COVERS			94	1,404		20	70	70	1,365	16
17	FAUCETS & COURTERS			94	2,192		20	110	110	2,145	17
18	PRIVACY SCREENS			94	2,182		20	109	109	2,125	18
19	REMODELING			94	89,471		20	4,474	4,474	87,243	19
20	HEATER			94	1,011		20	51	51	994	20
21	BREAKER PANELS			94	1,355		20	68	68	1,326	21
22	BREAKER PANELS			94	1,155		20	58	58	1,131	22
23	REMODELING			95	107,660		20	5,383	5,383	99,586	23
24	ROOF			96	4,921		20	246	246	4,271	24
25	GLASS BLOCK WINDOW, NEW A/C			96	30,000		20	1,500	1,500	26,268	25
26	REMOVE BRICK FENCE, REMOVE METAL OVERHANG			96	46,977		20	2,349	2,349	41,120	26
27	NEW WOOD OVERHANG, IRON RAILINGS, ETC			96	50,000		20	2,500	2,500	43,753	27
28	FURANCE			97	3,820		20	191	191	3,152	28
29	NEW CHIMNEYS, NEW DOWNSPROUTS, NEW FLOOR			97	30,000		20	1,500	1,500	24,734	29
30	FAUCETS & FLOORS, WINDOWS, HOT WATER HEATER			97	53,500		20	2,675	2,675	44,135	30
31	DRYWALL & DOORS IN BASEMENTS, NEW TILES			97	42,500		20	2,125	2,125	35,068	31
32	DOORS, REPLACE TILES, NEW FIXTURES, FAUCETS, TUCKP			97	7,500		20	375	375	6,201	32
33	TUCKPOINTING, PAINTING, REPAIR WALLS, SKYLIGHT			98	43,807		20	2,190	2,190	33,945	33
34	BUILD SCREENED IN PORCH			98	3,295		20	165	165	2,557	34
35	FIRE DOORS, TILING, LIGHT FIXTURES, PAINTING			98	18,600		20	930	930	14,415	35
36	ALUMINUM GUTTERS & DOWNSPOUTS			99	4,350		20	217	217	3,147	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number BELMONT NURSING HOME # 0024968 Report Period Beginning: 07/01/2012 Ending: 06/30/2013

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	PIPED & WIRED A/C RECEPTACLE A/C	2000	$ 7,045	$	20	$ 352	$ 352	$ 4,752	37
38	INSTALL WOOD DOOR, LIGHT FIXTURES, PAINTING	2000	4,825		20	241	241	3,254	38
39	PAINTING, LIGHT FIXTURES, TILE FLOORS	2000	4,100		20	205	205	2,768	39
40	FIRE SYSTEM	2000	1,645		20	82	82	1,107	40
41	REPLACE SIDEWALKS AND STAIRS	2000	3,100		20	155	155	2,093	41
42	SUPPLY & INSTALL 4 BATHROOM SINKS, FAUCETS, PLUM	2000	2,650		20	133	133	1,795	42
43	CUSTOM COUNTERS FOR NURSING STATION	2000	2,625		20	131	131	1,769	43
44	CUSTOM BUILD & INSTALL CABINETS IN MED ROOM	2000	3,750		20	188	188	2,538	44
45	FIRE SPRINKLER SYSTEM	2001	7,272		20	364	364	4,550	45
46	23 EXIT SIGNS	2001	4,108		20	205	205	2,563	46
47	FIRE PROTECTION SYSTEM	2001	4,959		20	248	248	3,100	47
48	FIRE ALARM	2002	935		20	47	47	540	48
49	PIPED & WIRED A/C RECEPTACLE A/C	2003	4,759		20	238	238	2,499	49
50	TILING	2004	16,415		20	821	821	7,799	50
51	FENCE	2004	3,276		20	164	164	1,558	51
52	ELECTRICAL WORK	2005	2,500		20	125	125	1,063	52
53	TILING	2005	1,500		20	75	75	638	53
54	SPRINKLER HEADS FOR FIRE PROTECTION	2006	4,450		20	223	223	1,672	54
55	FIRE ESCAPE REPAIR	2006	3,150		20	158	158	1,185	55
56	WINDOW TREATMENTS	2006	721		20	36	36	270	56
57	NEW FIRE ALARM SYSTEM	2007	62,645		20	3,132	3,132	20,358	57
58	TUCKPOINTING BUILDING	2007	8,850		20	442	442	2,873	58
59	NEW SIDEWALKS	2007	5,828		20	292	292	1,898	59
60	REPAIR ROOF, SKYLIGHT & DOWNSPROUTS	2007	5,450		20	272	272	1,768	60
61	REPAIR FENCE, GATES AND STAIR RAILINGS	2007	4,050		20	202	202	1,313	61
62	DRAW NEW FIRE ALARM SYSTEM	2007	5,260		20	264	264	1,716	62
63	NEW DOOR AND LOCK IN KITCHEN	2007	1,652		20	82	82	533	63
64	NEW HEATING & AIR CONDITIONING SYSTEM	2008	9,380		20	469	469	2,580	64
65	NEW ROOF	2008	21,270		20	1,064	1,064	5,852	65
66	FIRE ALARM PROTECTION INSTALLATION	2008	3,844		20	192	192	1,056	66
67	LAMINATE FLOORING	2008	8,085		20	404	404	2,222	67
68	PAINTING ALL ROOMS, HALLWAYS, OFFICES, ETC	2008	40,405		20	2,020	2,020	11,110	68
69	NEW FLOORING	2010	7,161		20	179	179	716	69
70	TOTAL (lines 4 thru 69)		$ 1,054,191	$		$ 42,317	$ 42,317	$ 821,015	70

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

Facility Name & ID Number BELMONT NURSING HOME # 0024968 Report Period Beginning: 07/01/2012 Ending: 06/30/2013

XI. OWNERSHIP COSTS (continued)

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

1	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,054,191	$		$ 42,317	$ 42,317	$ 821,015	1
2	SPRINKLER HEADS FOR FIRE PROTECTION	2010	3,490		20	175	175	612	2
3	CEMENT WORK IN PATIO	2011	2,925		20	73	73	146	3
4	INSTALL 6' HIGH CINDER BLOCK WALL	2011	2,765		20	69	69	138	4
5	CUBLICLE CURTAINS & TRACKS	2011	20,925		20	523	523	1,046	5
6	FENCE	2011	4,373		20	109	109	218	6
7	REDO OPENING INTO KITCHEN (DOOR,FRAME,HDWARE)	2011	5,662		20	142	142	284	7
8	NEW PIPING, MOP BASIN,AND FAUCETS	2011	4,498		20	112	112	224	8
9	NEW ELECTRICAL PIPING FOR NEW WATER HEATER	2011	3,821		20	96	96	192	9
10	west wing first floor shower room rehab-flooring, plumbing,concre	2011	32,680		20	817	817	1,634	10
11	EXTERIOR STEEL STAIRWAY	2011	20,173		20	504	504	1,008	11
12	CIRCUITS FOR A/C UNITS	2011	9,765		20	244	244	488	12
13	repair wire lath painted plaster ceiling in west wing basement	2011	6,852		20	171	171	342	13
14	REDO OPENING INTO CONF ROOM (DOOR,FRAME,HDWE)	2011	4,800		20	120	120	240	14
15	SPRINKLER HEADS	2011	5,900		20	148	148	296	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,182,820	$		$ 45,620	$ 45,620	$ 827,883	34

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

Facility Name & ID Number BELMONT NURSING HOME # 0024968 Report Period Beginning: 07/01/2012 Ending: 06/30/2013

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	$ 116,794	$	$ 11,221	$ 11,221	10 YRS	$ 48,441	71
72	Current Year Purchases	11,233		562	562	10 YRS	562	72
73	Fully Depreciated Assets	280,730					280,730	73
74								74
75	TOTALS	$ 408,757	$	$ 11,783	$ 11,783		$ 329,733	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,637,827	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 57,403	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 57,403	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,157,616	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number BELMONT NURSING HOME # 0024968 Report Period Beginning: 07/01/2012 Ending: 06/30/2013

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: GENEVA INC CO
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1999	61		$ 305,176	10		3
4	Additions							4
5								5
6								6
7	TOTAL		61		$ 305,176 **			7

8. List separately any amortization of lease expense included on page 4, line 34. 30,000
   This amount was calculated by dividing the total amount to be amortized 300,000
   by the length of the lease 10 .

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

10. Effective dates of current rental agreement:
    Beginning 6/01/06
    Ending 5/31/16

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

	Fiscal Year Ending	Annual Rent
12.	6/30/2014	$ 228,948
13.	6/30/2015	$ 228,948
14.	6/30/2016	$ 228,948

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: $ _____ Description: _____
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number BELMONT NURSING HOME # 0024968 Report Period Beginning: 07/01/2012 Ending: 06/30/2013

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 BELMONT NURSING HOME # 0024968 Report Period Beginning: 07/01/2012 Ending: 06/30/2013

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs							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							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			$		$	$		$	14

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

Facility Name & ID Number BELMONT NURSING HOME # 0024968 Report Period Beginning: 07/01/2012 Ending: 06/30/2013

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2013 (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	$ 15,033	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	189,802		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	35,098		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	20,725		8
9	Other(specify): Real Estate Escrow Dep.	2,516		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 263,174	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	46,250		13
14	Buildings, at Historical Cost	138,750		14
15	Leasehold Improvements, at Historical Cost	1,044,071		15
16	Equipment, at Historical Cost	408,757		16
17	Accumulated Depreciation (book methods)	(316,411)		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): Rent Security Dep.	87,500		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,408,917	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,672,091	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 71,266	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	55,897		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)**	$ 127,163	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	462,381		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 462,381	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 589,544	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,082,547	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,672,091	$	48

***(See instructions.)**

Facility Name & ID Number BELMONT NURSING HOME # 0024968 Report Period Beginning: 07/01/2012 Ending: 06/30/2013

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,322,511	1
2	Restatements (describe):		2
3		(1)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,322,510	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(239,963)	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)**	$ (239,963)	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)**	$ 1,082,547	24 *

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

Facility Name & ID Number BELMONT NURSING HOME # 0024968 Report Period Beginning: 07/01/2012 Ending: 06/30/2013

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	$ 2,144,731	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,144,731	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***	34,986	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 34,986	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,179,717	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	543,077	31
32	Health Care	666,350	32
33	General Administration	661,513	33
	B. Capital Expense		
34	Ownership	376,771	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	171,969	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,419,680	40
41	**Income before Income Taxes (line 30 minus line 40)****	(239,963)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (239,963)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,683,085	44
45	Private Pay - Net Inpatient Revenue	1,906	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) PERSONAL PORTION	457,928	47
48	Other-(specify) INSURANCE,VA,ETC	1,812	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,144,731	49

****TAX RETURN PREPARED ON CASH BASIS**

* **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.**

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

Facility Name & ID Number BELMONT NURSING HOME # 0024968 Report Period Beginning: 07/01/2012 Ending: 06/30/2013

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	1,912	2,080	$ 71,280	$ 34.27	1
2	Assistant Director of Nursing	467	475	13,197	27.78	2
3	Registered Nurses	1,056	1,056	42,250	40.01	3
4	Licensed Practical Nurses	8,719	9,430	249,123	26.42	4
5	CNAs & Orderlies	12,978	13,702	132,926	9.70	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,323	1,627	20,794	12.78	9
10	Activity Assistants	76	76	656	8.63	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,456	1,832	36,640	20.00	13
14	Head Cook	4,225	4,564	48,831	10.70	14
15	Cook Helpers/Assistants					15
16	Dishwashers	4,062	4,485	53,116	11.84	16
17	Maintenance Workers	2,372	2,770	64,448	23.27	17
18	Housekeepers	4,629	5,031	54,690	10.87	18
19	Laundry					19
20	Administrator	1,920	2,080	67,475	32.44	20
21	Assistant Administrator	1,920	2,080	33,000	15.87	21
22	Other Administrative	1,960	2,080	150,000	72.12	22
23	Office Manager					23
24	Clerical	1,238	1,352	38,350	28.37	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	3,624	4,016	97,249	24.22	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	53,937	58,736	$ 1,174,025 *	$ 19.99	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	$ 2,736	1-3	35
36	Medical Director	O	0	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	2,271	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	4,683	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 9,690		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	69	630	10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)	69	$ 630		53

Facility Name & ID Number BELMONT NURSING HOME # 0024968 Report Period Beginning: 07/01/2012 Ending: 06/30/2013

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
LAURIE HERTZ	ADMINISTRATOR		$ 53,875
MILDRED SHEPPARD	ASST ADMIN		33,000
EILEEN CONWAY	OTHER ADMIN	100	150,000
DONNA T. HARRIS	ADMINISTRATOR		13,600
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 250,475

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
COMCAST CABLE	DATA PROCESSING	$ 899
KRUPNICK BOKOR	ACCOUNTING	4,000
ACHILLE BENKO & DUVALL	ACCOUNTING	32,865
SCHMIDT,SALZMAN & MORAN	LEGAL FEE	3,911
KEVIN CONWAY	LEGAL FEE	3,063
BARANSKLL,HAMMER	ARCHITECT FEES	640
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 45,378

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 20,900
Unemployment Compensation Insurance	5,735
FICA Taxes	84,202
Employee Health Insurance	84,994
Employee Meals	4,599
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	3,351
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	37,405
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 241,186

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	0
Health Care Worker Background Check	830
(Indicate # of checks performed)	
Patient Background Checks	0
TRUST/FRANCHISE/CONTRIB/ETC	3,500
MARKETING/ADV/PROMO	0
LICENSES/DUES/SUBSCRIPTIONS	13,043
MGMT CO ALLOC	
TRUST/FRANCHISE/CONTRIB/ETC	(3,500)
Less: Public Relations Expense	(0)
Non-allowable advertising	(0)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,873

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)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number BELMONT NURSING HOME # 0024968 Report Period Beginning: 07/01/2012 Ending: 06/30/2013

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													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number BELMONT NURSING HOME # 0024968 Report Period Beginning: 07/01/2012 Ending: 06/30/2013

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ALLIANCE FOR LIVING $ 7024**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line **10-2**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **171,969**
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. $ **4,599** 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.