FOR BHF USE

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

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0051904

Facility Name: BELLWOOD DEVELOPMENTAL CTR

Address: 105 EASTERN AVENUE (Number) BELLWOOD (City) 60104 (Zip Code)

County: COOK

Telephone Number: 708-547-3580 **Fax #** 708-547-5290

HFS ID Number:

Date of Initial License for Current Owners: 3/1/2012

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: JESSICA KOPP **Telephone Number:** 815-232-1324
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 1/1/2014 to 12/31/2014 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) DAVID ZARUBA
(Title) ADMINISTRATOR

Paid Preparer
(Signed) (Date)
(Print Name and Title) JESSICA KOPP, CPA
(Firm Name & Address) THOMPSON & KOPP INC, 206 S. GALENA AVE, STE 110, FREEPORT, IL 61032
(Telephone) 815-232-1324 Fax # 815-235-1050

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 BELLWOOD DEVELOPMENTAL CTR # 0051904 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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		Intermediate (ICF)			3
4	82	Intermediate/DD	82	29,930	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	82	TOTALS	82	29,930	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					10
11	ICF/DD	27,932	365	0	28,297	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,932	365		28,297	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.54%

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)

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 3/1/2012

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date 3/1/2012 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 _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2014 Fiscal Year: 12/31/2014

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

Facility Name & ID Number BELLWOOD DEVELOPMENTAL CTR # 0051904 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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	197,656	19,070	7,368	224,094		224,094		224,094			1
2	Food Purchase		143,883		143,883		143,883		143,883			2
3	Housekeeping	126,641	18,260		144,901		144,901		144,901			3
4	Laundry	80,560	7,817		88,377		88,377		88,377			4
5	Heat and Other Utilities			134,958	134,958		134,958	(71)	134,887			5
6	Maintenance	28,162		46,476	74,638		74,638		74,638			6
7	Other (specify):*											7
8	TOTAL General Services	433,019	189,030	188,802	810,851		810,851	(71)	810,780			8
	B. Health Care and Programs											
9	Medical Director			13,200	13,200		13,200		13,200			9
10	Nursing and Medical Records	1,299,248	95,916	40,680	1,435,844		1,435,844		1,435,844			10
10a	Therapy	21,683	496	31,900	54,079		54,079		54,079			10a
11	Activities	105,375	2,747		108,122		108,122		108,122			11
12	Social Services	54,927			54,927		54,927		54,927			12
13	CNA Training											13
14	Program Transportation			9,701	9,701		9,701		9,701			14
15	Other (specify):* CASE MANAGER	146,122			146,122		146,122		146,122			15
16	TOTAL Health Care and Programs	1,627,355	99,159	95,481	1,821,995		1,821,995		1,821,995			16
	C. General Administration											
17	Administrative	317,580		61,434	379,014		379,014		379,014			17
18	Directors Fees											18
19	Professional Services			66,101	66,101		66,101		66,101			19
20	Dues, Fees, Subscriptions & Promotions			21,262	21,262		21,262	(12,930)	8,332			20
21	Clerical & General Office Expenses	89,724	12,555	30,599	132,878		132,878		132,878			21
22	Employee Benefits & Payroll Taxes			437,010	437,010		437,010		437,010			22
23	Inservice Training & Education											23
24	Travel and Seminar			470	470		470		470			24
25	Other Admin. Staff Transportation			5,141	5,141		5,141		5,141			25
26	Insurance-Prop.Liab.Malpractice			51,334	51,334		51,334		51,334			26
27	Other (specify):* IDPH EXPENSE			488	488		488	(488)				27
28	TOTAL General Administration	407,304	12,555	673,839	1,093,698		1,093,698	(13,418)	1,080,280			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,467,678	300,744	958,122	3,726,544		3,726,544	(13,489)	3,713,055			29

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

Facility Name & ID Number BELLWOOD DEVELOPMENTAL CTR #0051904 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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			83,594	83,594		83,594		83,594			30
31	Amortization of Pre-Op. & Org.			46,649	46,649		46,649	(46,649)				31
32	Interest			188,775	188,775		188,775		188,775			32
33	Real Estate Taxes			128,929	128,929		128,929		128,929			33
34	Rent-Facility & Grounds			30,000	30,000		30,000		30,000			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* INCOME TAX			10,358	10,358		10,358	(10,358)				36
37	TOTAL Ownership			488,305	488,305		488,305	(57,007)	431,298			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			291,105	291,105		291,105		291,105			42
43	Other (specify):* DT PAYOUT			1,148,128	1,148,128		1,148,128		1,148,128			43
44	TOTAL Special Cost Centers			1,439,233	1,439,233		1,439,233		1,439,233			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,467,678	300,744	2,885,660	5,654,082		5,654,082	(70,496)	5,583,586			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 BELLWOOD DEVELOPMENTAL CTR # 0051904 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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	(71)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(488)	27		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(12,930)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(10,358)	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (23,847)		$	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	(46,649)	31	33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (46,649)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (70,496)		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.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

BELLWOOD DEVELOPMENTAL CTR

ID# 0051904

Report Period Beginning: 1/1/2014

Ending: 12/31/2014

	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 BELLWOOD DEVELOPMENTAL CTR # 0051904 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	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	(71)	0	0	0	0	0	0	0	0	0	0	(71)	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	(71)	0	0	0	0	0	0	0	0	0	0	(71)	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	(12,930)	0	0	0	0	0	0	0	0	0	0	(12,930)	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):*	(488)	0	0	0	0	0	0	0	0	0	0	(488)	27
28	TOTAL General Administration	(13,418)	0	0	0	0	0	0	0	0	0	0	(13,418)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(13,489)	0	0	0	0	0	0	0	0	0	0	(13,489)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BELLWOOD DEVELOPMENTAL CTR **#** 0051904 **Report Period Beginning:** 1/1/2014 **Ending:** 12/31/2014

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	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	(46,649)	0	0	0	0	0	0	0	0	0	0	(46,649)	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	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):*	(10,358)	0	0	0	0	0	0	0	0	0	0	(10,358)	36
37	**TOTAL Ownership**	(57,007)	0	0	0	0	0	0	0	0	0	0	(57,007)	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)**	(70,496)	0	0	0	0	0	0	0	0	0	0	(70,496)	45

Facility Name & ID Number BELLWOOD DEVELOPMENTAL CTR # 0051904 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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
MICHAEL NUDELL	25%	STOCKTON HEALTHCARE & REHAB	STOCKTON, IL			
YEHUDIT GOLDBERG	25%	WILLOW OF MARENGO	MARENGO, IL			
ZVI FEINER	5%	ELMWOOD TERRACE HEALTHCARE CENTER	AURORA, IL			
JOSEPH BRANDMAN (Custodian for	45%	CRESTVIEW NURSING & REHABILITATION	WEBSTER CITY, IA			
children)		CAMBRIDGE HEALTHCARE & REHABILIATION	CAMBRIDGE, OH			
		BARNESVILLE HEALTHCARE & REHABILITATIC	BARNESVILLE, OH			

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 BELLWOOD DEVELOPMENTAL CTR # 0051904 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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 BELLWOOD DEVELOPMENTAL CTR # 0051904 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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	JOSEPH BRANDMAN	SHAREHOLDER	MANAGEMENT	0.45		11	25.00	SALARY	$ 65,326	17-1	1
2	MICHAEL NUDELL	SHAREHOLDER	MANAGEMENT	0.25		20	50.00	SALARY	80,000	17-1	2
3	YEHUDIT GOLDBERG	SHAREHOLDER	MANAGEMENT	0.25		0	0.00		0	0	3
4	ZVI FEINER	SHAREHOLDER	DIRECTOR	0.05		0	0.00		0	0	4
5	JEREMY GOLDBERG	RELATIVE	MANAGEMENT	0.00		20	50.00	SALARY	80,000	17-1	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 225,326		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 BELLWOOD DEVELOPMENTAL CTR # 0051904 Report Period Beginning: 1/1/2014 Ending: 2/31/2014

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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 BELLWOOD DEVELOPMENTAL CTR # 0051904 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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	PRIVATE BANK MORTGAGE		X	MORTGAGE	$9,000.00	5/22/2012	$ 2,150,000	$ 2,150,000	5/31/2017	6.0000	$ 141,900	1
2	PAYABLE TO S. BRANDMAN	X		MORTGAGE		3/1/2012	2,500,000	450,000		10.0000	45,000	2
3												3
4												4
5												5
	Working Capital											
6	LINE OF CREDIT		X	OPERATING EXPENSE		5/22/2014	1,600,000	100,000	5/22/2015	4.2500	1,865	6
7	MEMBER LOAN	X		OPERATING EXPENSE		5/31/2014		80,000				7
8	AFFILIATED COMPANY	X		OPERATING EXPENSE				338,774				8
9	TOTAL Facility Related				$9,000.00		$ 6,250,000	$ 3,118,774			$ 188,765	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 6,250,000	$ 3,118,774			$ 188,765	15

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

*** 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 BELLWOOD DEVELOPMENTAL CTR # 0051904 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	290,811	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.)	$	272,428	2
3. Under or (over) accrual (line 2 minus line 1).	$	(18,383)	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)	$	147,312	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.	$	128,929	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2009		8
2010		9
2011		10
2012	120,451	11
2013	151,977	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BELLWOOD DEVELOPMENTAL CTR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0051904

CONTACT PERSON REGARDING THIS REPORT JESSICA KOPP

TELEPHONE 815-232-1324 FAX #: 815-235-1050

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

Enter the tax index number and real estate tax assessed for 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15-09-200-023		$ 151,976.84	$ 151,976.84
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 151,976.84	$ 151,976.84

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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 BELLWOOD DEVELOPMENTAL CTR # 0051904 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,330 B. General Construction Type: Exterior BRICK Frame WOOD Number of Stories 1

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

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

D. Does the Operating Entity? [ ] (a) Own the Equipment [X] (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? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 699,736 2. Number of Years Over Which it is Being Amortized: 15

3. Current Period Amortization: 46,649 4. Dates Incurred: 3/1/2012, 3/12/2012, 5/22/2012

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	196,000	2012	$ 400,000	1
2					2
3	TOTALS	196,000		$ 400,000	3

Facility Name & ID Number BELLWOOD DEVELOPMENTAL CTR # 0051904 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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	82		2012		$ 902,000	$ 22,550	40	$ 22,550	$	$ 63,892	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	BUILDING IMPROVEMENTS - GROUPED			2013	334,151	8,354	40	8,354	0	10,442	9
10	WINDOW TREATMENTS			2014	4,495	375	10	375	0	375	10
11	TILE REPLACEMENT			2014	2,217	46	40	46	(0)	46	11
12	WALL PANELS			2014	1,682	35	40	35		35	12
13	FREIGHT & DELIVERY			2014	111	9	40	9		9	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

*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 BELLWOOD DEVELOPMENTAL CTR # 0051904 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,244,655	$ 31,369		$ 31,369	$ 0	$ 74,799	70

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

Facility Name & ID Number BELLWOOD DEVELOPMENTAL CTR # 0051904 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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	$ 354,849	$ 50,185	$ 50,185	$ 0	7	$ 140,068	71
72	Current Year Purchases	4,610	274	274		7	274	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 359,459	$ 50,459	$ 50,459	$ 0		$ 140,342	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	PATIENT TRANSPORT	202 FORD E450 SUPER DUTY	2012	$ 8,831	$ 1,766	$ 1,766	$ (0)	5	$ 3,827	76
77										77
78										78
79										79
80	TOTALS			$ 8,831	$ 1,766	$ 1,766	$ (0)		$ 3,827	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)	$ 2,012,945	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 83,594	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 83,594	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 0	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 218,968	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 BELLWOOD DEVELOPMENTAL CTR # 0051904 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			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.	/2015	$
13.	/2016	$
14.	/2017	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(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 BELLWOOD DEVELOPMENTAL CTR # 0051904 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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.

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 BELLWOOD DEVELOPMENTAL CTR # 0051904 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of 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 BELLWOOD DEVELOPMENTAL CTR **#** 0051904 **Report Period Beginning:** 1/1/2014 **Ending:** 12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2014 **(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	$ 394,570	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	984,446		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	31,050		6
7	Other Prepaid Expenses	2,443		7
8	Accounts Receivable (owners or related parties)	339,274		8
9	Other(specify): Employee Advance	21		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,751,804	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	400,000		13
14	Buildings, at Historical Cost	1,244,656		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	368,291		16
17	Accumulated Depreciation (book methods)	(218,968)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	699,736		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(131,378)		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)**	$ 2,362,336	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,114,140	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 363,343	$	26
27	Officer's Accounts Payable	80,000		27
28	Accounts Payable-Patient Deposits	7,345		28
29	Short-Term Notes Payable	550,000		29
30	Accrued Salaries Payable	72,681		30
31	Accrued Taxes Payable (excluding real estate taxes)	13,721		31
32	Accrued Real Estate Taxes(Sch.IX-B)	147,312		32
33	Accrued Interest Payable	11,844		33
34	Deferred Compensation	58,506		34
35	Federal and State Income Taxes	1,833		35
	Other Current Liabilities(specify):			
36	DUE TO AFFILIATED COMPANIES	27,306		36
37	OTHER MISC CURRENT	18,721		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,352,613	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,150,000		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)**	$ 2,150,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,502,613	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 611,526	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,114,140	$	48

***(See instructions.)**

Facility Name & ID Number BELLWOOD DEVELOPMENTAL CTR # 0051904 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 131,961	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 131,961	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	684,565	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	(205,000)	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)**	$ 479,565	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)**	$ 611,526	24 *

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

Facility Name & ID Number BELLWOOD DEVELOPMENTAL CTR # 0051904 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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	$ 5,188,858	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,188,858	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***	86	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 86	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DT BILLING ASPIRE	1,148,128	28
28a	VENDING & SCRAP SOLD	1,575	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,149,703	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,338,647	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	810,851	31
32	Health Care	1,821,995	32
33	General Administration	1,093,698	33
	B. Capital Expense		
34	Ownership	488,305	34
	C. Ancillary Expense		
35	Special Cost Centers	1,148,128	35
36	Provider Participation Fee	291,105	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,654,082	40
41	**Income before Income Taxes (line 30 minus line 40)****	684,565	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 684,565	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,458,295	44
45	Private Pay - Net Inpatient Revenue	63,153	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) SSA/SSI	606,394	47
48	Other-(specify) HOSPICE	61,016	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,188,858	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 BELLWOOD DEVELOPMENTAL CTR # 0051904 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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	1,729	1,991	$ 66,422	$ 33.36	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,005	10,479	250,001	23.86	3
4	Licensed Practical Nurses	2,134	2,334	57,536	24.65	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,883	2,054	29,726	14.47	9
10	Activity Assistants	7,785	8,006	75,649	9.45	10
11	Social Service Workers	1,815	2,080	54,927	26.41	11
12	Dietician					12
13	Food Service Supervisor	1,897	2,071	28,987	14.00	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,825	17,132	168,669	9.85	15
16	Dishwashers					16
17	Maintenance Workers	2,072	2,484	28,162	11.34	17
18	Housekeepers	12,316	13,172	126,641	9.61	18
19	Laundry	6,648	7,120	80,560	11.31	19
20	Administrator	2,107	2,107	92,254	43.78	20
21	Assistant Administrator					21
22	Other Administrative			333,956		22
23	Office Manager					23
24	Clerical	6,377	6,613	86,671	13.11	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	1,817	1,907	27,147	14.24	28
29	Resident Services Coordinator	6,675	7,395	118,975	16.09	29
30	Habilitation Aides (DD Homes)	75,713	80,648	838,343	10.40	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) JURY DUTY/BONUS			3,052		33
34	TOTAL (lines 1 - 33)	157,798	167,593	$ 2,467,678 *	$ 14.72	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	136	$ 7,368	1-3	35
36	Medical Director	120	13,200	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,153	10-3	39
40	Physical Therapy Consultant	129	8,755	10a-3	40
41	Occupational Therapy Consultant	177	8,825	10-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	125	8,234	10-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) BEHAVORIAL	365	19,324	10-3	46
47	DENTIST	10	633	10-3	47
48	DT/PYSCHIATRIST/PSYCHOLOGY	204	23,657	10-3	48
49	TOTAL (lines 35 - 48)	1,265	$ 93,148		49

C. CONTRACT NURSES

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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
DAVID ZARUBA	ADMINISTRATOR	0	$ 92,254
MICHAEL NUDELL	MANAGEMENT	25%	80,000
JEREMY GOLDBERG	MANAGEMENT	25%	80,000
JOSEPH BRANDMAN	MANAGEMENT	45%	65,326
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 317,580

B. Administrative - Other

Description	Amount
MANAGEMENT FEE TO ABS	$ 61,434
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 61,434

C. Professional Services

Vendor/Payee	Type	Amount
INTUIT	PAYROLL PROCESSING	$ 4,457
FIRST REAL ESTATE SERVICES	APPRAISAL	2,750
MARGEL & PEDDICORD CPA	CPA	518
MEYER MAGENCE	LEGAL	1,063
MTS CONSULTING	PAYROLL CONSULTING	722
PERSONNEL PLANNERS INC	PAYROLL MGMT	2,188
SEYFARTH SHAW	LEGAL	2,775
STEPHEN SHER	LEGAL	1,441
THOMPSON & KOPP INC	ACCOUNTANT	50,000
TWIN MED	OTHER	187
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 66,101

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 73,118
Unemployment Compensation Insurance	57,235
FICA Taxes	186,168
Employee Health Insurance	117,750
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
STAFF MEETINGS	2,739
TOTAL (agree to Schedule V, line 22, col.8)	$ 437,010

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	195
Health Care Worker Background Check	1,840
(Indicate # of checks performed)	
Patient Background Checks	
ADVERTISING & PROMOTION	12,930
PROSPECT RESOURCES	750
IHCA DUES	5,297
LLC FILING FEE	250
Less: Public Relations Expense	(12,930)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,332

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
TRAVEL EXPENSE	145
Seminar Expense	
PROFESSIONAL DEVELOPMENT	325
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 470

**See instructions.

Facility Name & ID Number BELLWOOD DEVELOPMENTAL CTR # 0051904 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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 BELLWOOD DEVELOPMENTAL CTR # 0051904 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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. **IHCA $5297**

(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? **7**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **28,810** Line **10**

(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. $ **291,105**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? 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? **100%**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **COMPILATION**
Firm Name: **THOMPSON & KOPP INC**

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **YES**
Attach invoices and a summary of services for all architect and appraisal fees