FOR BHF USE

LL1

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

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: 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 07/01/2013 to 06/30/2014 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) EILEEN CONWAY
(Title) PRESIDENT

Paid Preparer

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

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

Facility Name & ID Number BELMONT NURSING HOME # 0024968 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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	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	18,400			18,400	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,400			18,400	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.64%

D. How many bed-hold days during this year were paid by the Department? _____ (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 [X]

Tax Year: 12/31/2014 Fiscal Year: 06/30/2014

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

Facility Name & ID Number BELMONT NURSING HOME # 0024968 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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	134,473	25,721	2,736	162,930		162,930		162,930			1
2	Food Purchase		101,728		101,728	(4,599)	97,129	(1,032)	96,097			2
3	Housekeeping	62,875	38,230		101,105		101,105		101,105			3
4	Laundry											4
5	Heat and Other Utilities			37,618	37,618		37,618		37,618			5
6	Maintenance	48,944	13,017	2,458	64,419		64,419		64,419			6
7	Other (specify):* SCAVENGER			9,081	9,081		9,081		9,081			7
8	TOTAL General Services	246,292	178,696	51,893	476,881	(4,599)	472,282	(1,032)	471,250			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	553,228	38,193	30,181	621,602		621,602		621,602			10
10a	Therapy											10a
11	Activities	21,699	9,689		31,388		31,388		31,388			11
12	Social Services	5,758		3,087	8,845		8,845		8,845			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	580,685	47,882	33,268	661,835		661,835		661,835			16
	C. General Administration											
17	Administrative	225,645			225,645		225,645		225,645			17
18	Directors Fees											18
19	Professional Services			31,798	31,798		31,798		31,798			19
20	Dues, Fees, Subscriptions & Promotions			12,181	12,181		12,181	(2,200)	9,981			20
21	Clerical & General Office Expenses	50,300	31,671	7,369	89,340		89,340		89,340			21
22	Employee Benefits & Payroll Taxes			210,733	210,733	4,599	215,332		215,332			22
23	Inservice Training & Education			3,983	3,983		3,983	(1,573)	2,410			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			11	11		11		11			25
26	Insurance-Prop.Liab.Malpractice			29,963	29,963		29,963		29,963			26
27	Other (specify):*											27
28	TOTAL General Administration	275,945	31,671	296,038	603,654	4,599	608,253	(3,773)	604,480			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,102,922	258,249	381,199	1,742,370		1,742,370	(4,805)	1,737,565			29

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	DIETARY		TOTAL
1	DIETITIAN CONSULTANT	2,736.00	**2,736.00**
5	HEAT & OTHER UTILITIES		
	CABLE TV-LOBBY	1,079.00	
	UTILITIES	36,539.00	**37,618.00**
6	MAINTENANCE		
	FIRE SERVICE	2,458.00	**2,458.00**
7	OTHER		
	SCAVENG	9,081.00	**9,081.00**
10	NURSING		
	CONTRACT NURSING	27,243.00	
	PHARMACY CONSULTANT	2,938.00	**30,181.00**
12	SOCIAL SERVICES		
	SOCIAL WORKER	3,087.00	**3,087.00**
19	PROFESSIONAL SERVICES		
	DATA PROCESSING	899.00	
	PROFESSIONAL FEES	30,899.00	**31,798.00**
20	FEES,SUBSCRIPTIONS,PROMOTIONS		
	CONTRIBUTIONS	2,200.00	
	DUES & SUBSCRIPTIONS	8,444.00	
	LICENSES & PERMITS	120.00	
	HEALTH CARE WORKER BACKGROUND CHEC	650.00	
	EMPLOYEE WANT ADS	767.00	**12,181.00**

LINE			TOTAL
21	CLERICAL & GENERAL OFFICE EXPENSES		
	TELEPHONE	2,674.00	
	BANK CHARGE	10.00	
	EQUIPMENT REPAIRS & MAINT.	1,742.00	
	PENALTIES	2,943.00	**7,369.00**
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	FICA TAXES	81,752.00	
	UNEMPLOYMENT COMPENSATION	5,299.00	
	WORKERS COMPENSATION INSURANCE	13,637.00	
	HOSPITALIZATION INSURANCE	74,940.00	
	EMPLOYEE BENEFIT - OTHER	5,407.00	
	PENSION/PROFIT SHARING PLANS	29,698.00	**210,733.00**
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS	3,983.00	**3,983.00**
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF	11.00	**11.00**
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE	29,963.00	**29,963.00**
	Grand total column 3 other		381,199.00

BELMONT NURSING HOME
SCHEDULES
06/30/2014

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: 07/01/2013 Ending: 06/30/2014

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							52,681	52,681			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			24,242	24,242		24,242	(7,687)	16,555			32
33	Real Estate Taxes			51,319	51,319		51,319		51,319			33
34	Rent-Facility & Grounds			293,209	293,209		293,209		293,209			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			368,770	368,770		368,770	44,994	413,764			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			25,782	25,782		25,782		25,782			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			25,782	25,782		25,782		25,782			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,102,922	258,249	775,751	2,136,922		2,136,922	40,189	2,177,111			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: 07/01/2013 Ending: 06/30/2014

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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	52,681	30		9
10	Interest and Other Investment Income	(7,687)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,032)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(2,200)	20		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				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 41,762		$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,573)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,573)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 40,189		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

BELMONT NURSING HOME

ID# 0024968

Report Period Beginning: 07/01/2013

Ending: 06/30/2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	SEMINARS	$ (1,573)	23	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**	(1,573)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BELMONT NURSING HOME # 0024968 **Report Period Beginning:** 07/01/2013 **Ending:** 06/30/2014

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	(1,032)	0	0	0	0	0	0	0	0	0	0	(1,032)	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**	(1,032)	0	0	0	0	0	0	0	0	0	0	(1,032)	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	(2,200)	0	0	0	0	0	0	0	0	0	0	(2,200)	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	(1,573)	0	0	0	0	0	0	0	0	0	0	(1,573)	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**	(3,773)	0	0	0	0	0	0	0	0	0	0	(3,773)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(4,805)	0	0	0	0	0	0	0	0	0	0	(4,805)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BELMONT NURSING HOME # 0024968 **Report Period Beginning:** 07/01/2013 **Ending:** 06/30/2014

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	52,681	0	0	0	0	0	0	0	0	0	0	52,681	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(7,687)	0	0	0	0	0	0	0	0	0	0	(7,687)	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**	44,994	0	0	0	0	0	0	0	0	0	0	44,994	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)**	40,189	0	0	0	0	0	0	0	0	0	0	40,189	45

Facility Name & ID Number BELMONT NURSING HOME # 0024968 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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
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: 07/01/2013 Ending: 06/30/2014

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 BELMONT NURSING HOME # 0024968 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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	EILEEN CONWAY	PRESIDENT	FINANCE	100.00		40	100.00	SALARY	$ 125,000	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	$ 125,000		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: 07/01/2013 Ending: 6/30/2014

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 [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: 07/01/2013 Ending: 06/30/2014

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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	INLAND BANK		X	WORKING CAPITAL	$2,200.00	10/19/05		89,780	10/19/17	6.5000	6,853	6
7	COMMUNITY BANK		X	LINE OF CREDIT	INT ONLY		100,000	95,000	REVOLV	PRIME+	5,952	7
8	SHAREHOLDER LOAN	X		WORKING CAPITAL							11,437	8
9	TOTAL Facility Related				$2,200.00		$ 100,000	$ 184,780			$ 24,242	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 100,000	$ 184,780			$ 24,242	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: 07/01/2013 Ending: 06/30/2014

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.**	$ 55,897	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.)		$ 58,671	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,774	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 56,655	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** $ 8,110 **For** 2010 **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$ (8,110)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 51,319	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	48,593	8
	2010	49,915	9
	2011	49,707	10
	2012	55,490	11
	2013	56,242	12

REAL ESTATE TAXES PAID IS THE 2012 SECOND INSTALLMENT OF 28,151 PLUS THE 2013 FIRST INSTALLMENT OF 30,520

	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 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 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.	14-19-432-030-0000	NURSING HOME	$ 11,616.52	$ 11,616.52
2.	14-19-432-031-0000	NURSING HOME	$ 14,974.65	$ 14,974.65
3.	14-19-432-032-0000	NURSING HOME	$ 29,650.33	$ 29,650.33
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 56,241.50	$ 56,241.50

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 BELMONT NURSING HOME # 0024968 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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).

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: 07/01/2013 Ending: 06/30/2014

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			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			72,104	15
16	RADIATOR COVERS			94	1,404		20	39	39	1,404	16
17	FAUCETS & COURTERS			94	2,192		20	47	47	2,192	17
18	PRIVACY SCREENS			94	2,182		20	57	57	2,182	18
19	REMODELING			94	89,471		20	2,228	2,228	89,471	19
20	HEATER			94	1,011		20	17	17	1,011	20
21	BREAKER PANELS			94	1,355		20	29	29	1,355	21
22	BREAKER PANELS			94	1,155		20	24	24	1,155	22
23	REMODELING			95	107,660		20	5,383	5,383	104,969	23
24	ROOF			96	4,921		20	246	246	4,517	24
25	GLASS BLOCK WINDOW, NEW A/C			96	30,000		20	1,500	1,500	27,768	25
26	REMOVE BRICK FENCE, REMOVE METAL OVERHANG			96	46,977		20	2,349	2,349	43,469	26
27	NEW WOOD OVERHANG, IRON RAILINGS, ETC			96	50,000		20	2,500	2,500	46,253	27
28	FURANCE			97	3,820		20	191	191	3,343	28
29	NEW CHIMNEYS, NEW DOWNSPROUTS, NEW FLOOR			97	30,000		20	1,500	1,500	26,234	29
30	FAUCETS & FLOORS, WINDOWS, HOT WATER HEATER			97	53,500		20	2,675	2,675	46,810	30
31	DRYWALL & DOORS IN BASEMENTS, NEW TILES			97	42,500		20	2,125	2,125	37,193	31
32	DOORS, REPLACE TILES, NEW FIXTURES, FAUCETS, TUCKP			97	7,500		20	375	375	6,576	32
33	TUCKPOINTING, PAINTING, REPAIR WALLS, SKYLIGHT			98	43,807		20	2,190	2,190	36,135	33
34	BUILD SCREENED IN PORCH			98	3,295		20	165	165	2,722	34
35	FIRE DOORS, TILING, LIGHT FIXTURES, PAINTING			98	18,600		20	930	930	15,345	35
36	ALUMINUM GUTTERS & DOWNSPOUTS			99	4,350		20	217	217	3,364	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: 07/01/2013 Ending: 06/30/2014

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	PIPED & WIRED A/C RECEPTACLE A/C	2000	$ 7,045	$	20	$ 352	$ 352	$ 5,104	37
38	INSTALL WOOD DOOR, LIGHT FIXTURES, PAINTING	2000	4,825		20	241	241	3,495	38
39	PAINTING, LIGHT FIXTURES, TILE FLOORS	2000	4,100		20	205	205	2,973	39
40	FIRE SYSTEM	2000	1,645		20	82	82	1,189	40
41	REPLACE SIDEWALKS AND STAIRS	2000	3,100		20	155	155	2,248	41
42	SUPPLY & INSTALL 4 BATHROOM SINKS, FAUCETS, PLUM	2000	2,650		20	133	133	1,928	42
43	CUSTOM COUNTERS FOR NURSING STATION	2000	2,625		20	131	131	1,900	43
44	CUSTOM BUILD & INSTALL CABINETS IN MED ROOM	2000	3,750		20	188	188	2,726	44
45	FIRE SPRINKLER SYSTEM	2001	7,272		20	364	364	4,914	45
46	23 EXIT SIGNS	2001	4,108		20	205	205	2,768	46
47	FIRE PROTECTION SYSTEM	2001	4,959		20	248	248	3,348	47
48	FIRE ALARM	2002	935		20	47	47	587	48
49	PIPED & WIRED A/C RECEPTACLE A/C	2003	4,759		20	238	238	2,737	49
50	TILING	2004	16,415		20	821	821	8,620	50
51	FENCE	2004	3,276		20	164	164	1,722	51
52	ELECTRICAL WORK	2005	2,500		20	125	125	1,188	52
53	TILING	2005	1,500		20	75	75	713	53
54	SPRINKLER HEADS FOR FIRE PROTECTION	2006	4,450		20	223	223	1,895	54
55	FIRE ESCAPE REPAIR	2006	3,150		20	158	158	1,343	55
56	WINDOW TREATMENTS	2006	721		20	36	36	306	56
57	NEW FIRE ALARM SYSTEM	2007	62,645		20	3,132	3,132	23,490	57
58	TUCKPOINTING BUILDING	2007	8,850		20	442	442	3,315	58
59	NEW SIDEWALKS	2007	5,828		20	292	292	2,190	59
60	REPAIR ROOF, SKYLIGHT & DOWNSPROUTS	2007	5,450		20	272	272	2,040	60
61	REPAIR FENCE, GATES AND STAIR RAILINGS	2007	4,050		20	202	202	1,515	61
62	DRAW NEW FIRE ALARM SYSTEM	2007	5,260		20	264	264	1,980	62
63	NEW DOOR AND LOCK IN KITCHEN	2007	1,652		20	82	82	615	63
64	NEW HEATING & AIR CONDITIONING SYSTEM	2008	9,380		20	469	469	3,049	64
65	NEW ROOF	2008	21,270		20	1,064	1,064	6,916	65
66	FIRE ALARM PROTECTION INSTALLATION	2008	3,844		20	192	192	1,248	66
67	LAMINATE FLOORING	2008	8,085		20	404	404	2,626	67
68	PAINTING ALL ROOMS, HALLWAYS, OFFICES, ETC	2008	40,405		20	2,020	2,020	13,130	68
69	NEW FLOORING	2010	7,161		20	179	179	895	69
70	TOTAL (lines 4 thru 69)		$ 1,054,191	$		$ 37,992	$ 37,992	$ 859,007	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: 07/01/2013 Ending: 06/30/2014

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	
1	Totals from Page 12A, Carried Forward		$ 1,054,191	$		$ 37,992	$ 37,992	$ 859,007	1
2	SPRINKLER HEADS FOR FIRE PROTECTION	2010	3,490		20	175	175	787	2
3	CEMENT WORK IN PATIO	2011	2,925		20	73	73	219	3
4	INSTALL 6' HIGH CINDER BLOCK WALL	2011	2,765		20	69	69	207	4
5	CUBLICLE CURTAINS & TRACKS	2011	20,925		20	523	523	1,569	5
6	FENCE	2011	4,373		20	109	109	327	6
7	REDO OPENING INTO KITCHEN (DOOR,FRAME,HDWARE)	2011	5,662		20	142	142	426	7
8	NEW PIPING, MOP BASIN,AND FAUCETS	2011	4,498		20	112	112	336	8
9	NEW ELECTRICAL PIPING FOR NEW WATER HEATER	2011	3,821		20	96	96	288	9
10	west wing first floor shower room rehab-flooring, plumbing,concre	2011	32,680		20	817	817	2,451	10
11	EXTERIOR STEEL STAIRWAY	2011	20,173		20	504	504	1,512	11
12	CIRCUITS FOR A/C UNITS	2011	9,765		20	244	244	732	12
13	repair wire lath painted plaster ceiling in west wing basement	2011	6,852		20	171	171	513	13
14	REDO OPENING INTO CONF ROOM (DOOR,FRAME,HDWE)	2011	4,800		20	120	120	360	14
15	SPRINKLER HEADS	2011	5,900		20	148	148	444	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	$		$ 41,295	$ 41,295	$ 869,178	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: 07/01/2013 Ending: 06/30/2014

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	$ 119,027	$	$ 11,386	$ 11,386	10 YRS	$ 51,386	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	289,730					289,730	73
74								74
75	TOTALS	$ 408,757	$	$ 11,386	$ 11,386		$ 341,116	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)	$ 52,681	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 52,681	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,210,294	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: 07/01/2013 Ending: 06/30/2014

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		$ 293,209	10		3
4	Additions							4
5								5
6								6
7	TOTAL		61		$ 293,209 **			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.	6/30/2015	$ 228,948
13.	6/30/2016	$ 228,948
14.	6/30/2017	$ 228,949

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: 07/01/2013 Ending: 06/30/2014

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 BELMONT NURSING HOME # 0024968 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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 BELMONT NURSING HOME # 0024968 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2014 (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	$ 134,794	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	148,320		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	34,946		6
7	Other Prepaid Expenses	900		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Real Estate Escrow Dep.	2,599		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 321,559	$	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	422,158		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 DEPOSIT	57,500		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,392,318	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,713,877	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 28,074	$	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)	56,655		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)**	$ 84,729	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	353,970		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)**	$ 353,970	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 438,699	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,275,178	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,713,877	$	48

***(See instructions.)**

Facility Name & ID Number BELMONT NURSING HOME # 0024968 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,082,547	1
2	Restatements (describe):		2
3	ROUNDING	4	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,082,551	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	192,627	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)**	$ 192,627	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)**	$ 1,275,178	24 *

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

Facility Name & ID Number BELMONT NURSING HOME # 0024968 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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	$ 2,277,133	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,277,133	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***	7,687	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 7,687	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)**	$ 2,284,820	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	476,881	31
32	Health Care	661,835	32
33	General Administration	603,654	33
	B. Capital Expense		
34	Ownership	368,770	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	25,782	36
	D. Other Expenses (specify):		
37	OUT OF PERIOD EXPENSES	(44,729)	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,092,193	40
41	**Income before Income Taxes (line 30 minus line 40)****	192,627	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 192,627	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,767,969	44
45	Private Pay - Net Inpatient Revenue	1,179	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) PERSONAL PORTION	506,173	47
48	Other-(specify) INSURANCE,VA,ETC	1,812	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,277,133	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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.**

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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	652	716	$ 28,631	$ 39.99	1
2	Assistant Director of Nursing	1,856	2,056	58,484	28.45	2
3	Registered Nurses	1,683	1,934	53,540	27.68	3
4	Licensed Practical Nurses	6,603	6,899	184,073	26.68	4
5	CNAs & Orderlies	12,129	13,150	126,718	9.64	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,860	1,908	21,699	11.37	9
10	Activity Assistants					10
11	Social Service Workers	559	607	5,758	9.49	11
12	Dietician					12
13	Food Service Supervisor	1,367	1,663	34,928	21.00	13
14	Head Cook	4,103	4,343	49,149	11.32	14
15	Cook Helpers/Assistants					15
16	Dishwashers	3,926	4,278	50,396	11.78	16
17	Maintenance Workers	1,843	2,203	48,944	22.22	17
18	Housekeepers	5,351	5,785	62,875	10.87	18
19	Laundry					19
20	Administrator	1,920	2,080	65,005	31.25	20
21	Assistant Administrator	1,920	2,080	35,640	17.13	21
22	Other Administrative	1,960	2,080	125,000	60.10	22
23	Office Manager					23
24	Clerical	1,896	2,080	50,300	24.18	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	3,715	4,059	101,782	25.08	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)	53,343	57,921	$ 1,102,922 *	$ 19.04	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	48	$ 2,736	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	month fee	2,938	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	45	3,087	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	93	$ 8,761		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	792	$ 27,000	10-3	50
51	Licensed Practical Nurses	5	130	10-3	51
52	Certified Nurse Assistants/Aides	12	113	10-3	52
53	TOTAL (lines 50 - 52)	809	$ 27,243		53

Facility Name & ID Number BELMONT NURSING HOME # 0024968 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
DONNA T. HARRIS	ADMINISTRATOR		$ 65,005
MILDRED SHEPPARD	ASST. ADMIN		35,640
EILEEN CONWAY	OTHER ADMIN	100	125,000
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 225,645

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	17,661
KEVIN CONWAY	LEGAL	3,000
SCHMIDT SALZMAN & MORAN	LEGAL	2,878
BARANSKI,HAMMER,MORETTA	ARCHITECT FEES	3,360
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 31,798

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 13,637
Unemployment Compensation Insurance	5,299
FICA Taxes	81,752
Employee Health Insurance	74,940
Employee Meals	4,599
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFIT - OTHER	5,407
PENSION/PROFIT SHARING PLANS	29,698
TOTAL (agree to Schedule V, line 22, col.8)	$ 215,332

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	
Health Care Worker Background Check	650
(Indicate # of checks performed)	
Patient Background Checks	
TRUST/FRANCHISE/CONTRIB/ETC	3,500
LICENSES/DUES/SUBSCRIPTIONS	9,331
TRUST/FRANCHISE/CONTRIB/ETC	(3,500)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,981

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
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: 07/01/2013 Ending: 06/30/2014

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 BELMONT NURSING HOME # 0024968 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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. **ALLIANCE FOR LIVING $7,908**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **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. $ **25,782**
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 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.