CHARLES H. FOLEY & ASSOCIATES INC.

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SENT VIA ELECTRONIC MAIL

February 24, 2011

RECEIVED

FEB 2 4 2011

HEALTH FACILITIES & SERVICES REVIEW BOARD

Mr. George Roate, Project Reviewer
Health Facilities and Services Review Board
Illinois Department of Public Health
525 West Jefferson Street, Second Floor
Springfield, Illinois 61761

RE: Project Number **11-013**, Bel-Wood Nursing Home, request for additional information.

Dear Mr. Roate:

On behalf of the Applicant for the above referenced project, please accept this correspondence as a response to the items you had requested as part of your completeness review. The items addressed and provided herein are:

1. Appended as **EXHIBIT I**, is the Applicant's address to criteria 1120.140 b), c), d), and e).

2. In response to your inquiry to the completion and submission of the Illinois Department of Public Health's Long-Term Care Facility Questionnaire for 2010, Bel-Wood Nursing Home's administrator has indicated that the report has been completed and filed. For your convenience a copy of this completed questionnaire form is appended as **EXHIBIT II**.

3. In accordance with your request into the issue of charity care by Bel-Wood Nursing Home, the Applicant has provided the statement enclosed as **EXHIBIT III**. It should be known that Long-Term Care facilities are not considered safety net providers and their charity care is not typically in adherence with the Review Board's definition of "Charity Care". This facility is a "County Home" and as such it takes all comers. Furthermore, historically, the facility's largest revenue source has been Medicaid. Appended as **EXHIBIT IV**, is the Subject facility's forecasted income statement illustrating that this will hold true upon project completion.

	2008	%	2009	%	2010	%	2015	%
Medicaid Pt.	193	72%	179	72.8%	172	74.8%	168	78.5%
Total Pt.	268		246		230		214	

Source: IDPH L-TC Facility Questionnaire, 2008, 2009 and 2010.
2015 Forecasted Income Statement.

The chart provided above also provides you with the historical and projected number of Medicaid residents as compared to total number of residents. From this data it is evident that the Applicant's commitment to this population is strong. Appended as **EXHIBIT V,** are the IDPH Long-Term Care Facility Questionnaires for 2008 and 2009.

I trust that this information addresses your concerns. Should you have any additional questions, please do not hesitate to contact me. Thank you in advance for your consideration.

Sincerely,

John P. Kniery
Health Care Consultant

ENCLOSURES

C: Patrick Urich, County Administrator
Scott Sorrell, Assistant to the County Administrator
Matt Niekirk, Bel-Wood Administrator
Michael Scavotto, Management Performance Associaties

X. 1120.140 - Economic Feasibility REVISED 2/22/2011

This section is applicable to all projects subject to Part 1120.

N/A **A. Reasonableness of Financing Arrangements- Moody's Aa2 Bond Rating for Peoria County's Bonds**

The applicant shall document the reasonableness of financing arrangements by submitting a notarized statement signed by an authorized representative that attests to one of the following:

1) That the total estimated project costs and related costs will be funded in total with cash and equivalents, including investment securities, unrestricted funds, received pledge receipts and funded depreciation; or

2) That the total estimated project costs and related costs will be funded in total or in part by borrowing because:

A) A portion or all of the cash and equivalents must be retained in the balance sheet asset accounts in order to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or

B) Borrowing is less costly than the liquidation of existing investments, and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

B. Conditions of Debt Financing

This criterion is applicable only to projects that involve debt financing. The applicant shall document that the conditions of debt financing are reasonable by submitting a notarized statement signed by an authorized representative that attests to the following, as applicable:

1) That the selected form of debt financing for the project will be at the lowest net cost available; **See ATTACHMENT-42A.**

2) That the selected form of debt financing will not be at the lowest net cost available, but is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional indebtedness, term (years), financing costs and other factors;

3) That the project involves (in total or in part) the leasing of equipment or facilities and that the expenses incurred with leasing a facility or equipment are less costly than constructing a new facility or purchasing new equipment.

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

1. Identify each department or area impacted by the proposed project and provide a cost and square footage allocation for new construction and/or modernization using the following format (insert after this page).

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE

Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New	Mod.	Gross Sq. Ft. New	Circ.*	Gross Sq. Ft. Mod.	Circ.*	Const. $ (A x C)	Mod. $ (B x E)	
Nursing	213.03		145,126				30,915,683		30,915,683
Contingency	21.30		145,126				3,091,568		3,091,568
TOTALS	234.33		145,126				34,007,251		34,007,251

* Include the percentage (%) of space for circulation

Further justification of cost per square foot is appended as ATTACHMENT-42B.

EXHIBIT I

D. Projected Operating Costs **REVISED 2/22/2011**

The applicant shall provide the projected direct annual operating costs (in current dollars per equivalent patient day or unit of service) for the first full fiscal year at target utilization but no more than two years following project completion. Direct cost means the fully allocated costs of salaries, benefits and supplies for the service.

E. Total Effect of the Project on Capital Costs

The applicant shall provide the total projected annual capital costs (in current dollars per equivalent patient day) for the first full fiscal year at target utilization but no more than two years following project completion.

To address items D and E above, please refer to ATTACHMENT-42C.

APPEND DOCUMENTATION AS ATTACHMENT 42, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

XI. Safety Net Impact Statement

This item is not germane to General Long-Term Care facilities

SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for ALL SUBSTANTIVE AND DISCONTINUATION PROJECTS:

1. The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge.

2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.

3. How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

Safety Net Impact Statements shall also include all of the following:

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.

2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.

3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

A table in the following format must be provided as part of Attachment 43.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	**Year**	**Year**	**Year**
Inpatient			
Outpatient			
Total			
Charity (cost in dollars)			
Inpatient			
Outpatient			
Total			
MEDICAID			
Medicaid (# of patients)	**Year**	**Year**	**Year**
Inpatient			
Outpatient			

To: Illinois Health Facilities and Services Review Board

From: Patrick Urich
County Administrator
Peoria County Government

Date: February 4, 2011

Re: Bel-Wood Nursing Home
Replacement Facility
Section 1120.140 – Economic Feasibility

On behalf of Peoria County, I certify that the County's debt will be sold in the municipal market place with a strong rating (currently Moody's Aa2) and through an Internet bidding platform, following a period of advertising of the sale, and that this method will ensure the lowest net interest cost available at the time of sale. I make this certification in response to criterion B.1, Conditions of Debt Financing.

My certification is consistent with the ordinance dated August 12, 2010 authorizing the issuance of General Obligation alternate revenue source bonds of the County of Peoria, Illinois, for the purpose of financing a new Peoria County nursing home, which ordinance is included in Peoria County's Certificate of Need application.

By: _____

Patrick Urich, County Administrator

Date: 2/4/11

Attest: _____

"OFFICIAL SEAL"
VIRGINIA PEARL
Notary Public, State of Illinois
My Commission Expires 08-24-2012

Notary Public

My commission expires 8/24/2012

X. 1120.140 - Economic Feasibility

C. Reasonableness of Project and Related Costs

	Construction	Sq. Ft	Building Cost/GSF
Bel-Wood Project	$ 30,915,683	145,126	$ 213.03
3/4 Means Nursing Homes	(CY2014)		$ 194.33
Difference			$ 18.70

	Plumbing	HVAC	Electrical	Total
Bel-Wood Project	$ 17.65	$ 31.67	$ 34.72	$ 84.04
3/4 Means Nursing Homes	$ 17.15	$ 19.50	$ 18.45	$ 55.10
Difference	$ 0.50	$ 12.17	$ 16.27	$ 28.94

Additional influences on the actual cost versus the ¾ levels of Means:

*Since January 2011 the price of structural steel has increased $150/ton

*Since January 2011 the price of raw copper has increased by 7%.

*This project proposes receive LEED certification.

*The Construction climate in Peoria is strong.

*100% Union Construction.

*Multiple story construction and complex systems

*For the above reasons, this project is easily above the thrid quartile of means costs.

	5.g	8.1 Glazing	$	456,312
	5.h	9.1 Drywall,Framing, Accoustics	$	2,811,143
	5.i	9.2 Flooring	$	811,409
	5.j	9.3 Painting & Wallcovering	$	546,582
	5.k	14.1 Elevators	$	213,500
	5.l	21.1 Fire Suppression	$	410,988
	5.m	22.1 Plumbing	$	2,562,000
	5.n	23.1 Mech/ HVAC	$	4,595,875
	5.o	26.1 Electrical	$	5,038,125
	5.p	Excavation & Backfill	$	469,503
	5.q	General Conditions	$	1,329,938
	5.r	Insurance & Bond	$	260,136
	5.s	CM Fee	$	958,707
		TOTAL	$	30,915,683
6		**MODERNIZATION CONTRACTS (NOT USED)**		
		TOTAL		
7		**CONTINGENCIES**		
	7.a	10% of Section 5, New Construction Projects	$	3,091,568
		TOTAL	$	3,091,568
8		**ARCHITECTURAL AND ENGINEERING FEES**		
	8.a	Criteria Design	$	517,937
	8.b	Detail Design	$	1,026,945
	8.c	Implementation Documents	$	514,961
	8.d	Bid and Buy	$	104,183
	8.e	Construction Admin.	$	434,591
	8.f	Closeout	$	23,813
	8.g	LEEDs	$	156,000
	8.h	Additional Services	$	256,379
	8.i	Reimbursibles	$	35,000
	8.J	Civil Engineering	$	120,000
	8.k	Alternates and Cost Reduction	$	172,732
	8.l	Demolition Documents	$	75,500
		TOTAL	$	3,438,041
9		**CONSULTING AND OTHER FEES**		
	9.a	IDPH Plan Review Fee	$	40,000
	9.b	Phase 1 Environmental	$	4,800
	9.c	Cultural Resources Survey	$	500
	9.d	CON Consultant	$	60,000
	9.e	Utility Capacity Charges	$	10,000
	9.f	Builders Risk Insurance	$	65,000
	9.g	Materials Testing	$	65,000
	9.h	Project Planning and Management Fee	$	1,282,543
		TOTAL	$	1,527,843

10	**MOVEABLE OR OTHER EQUIPMENT**		
	10.a	6.1 Laundry Equipment	$ 243,857
	10.b	6.1 Residential Appliances	$ 15,250
	10.c	11.1 Food Service Equipment	$ 418,673
	10.d	General Conditions	$ 6,677
	10.e	Bond & Insurance	$ 25,108
	10.f	CM Fee	$ 23,722
	10.g	Owner furnished Furnished FF&E	$ 743,700
		TOTAL	**$ 1,476,988**
11	**BOND ISSUANCE EXPENSE**		
	11.a	Bond Issuance Expense	$ 535,000
		TOTAL	**$ 535,000**
12	**NET INTEREST DURING CONSTRUCTION**		
	12.a	Net Interest During Construction	$ 3,460,000
		TOTAL	**$ 3,460,000**
13	**FAIR MARKET VALUE OF LEASED SPACE OR EQUIPMENT (NOT USED)**		
	13.a		
		TOTAL	
14	**OTHER COSTS TO BE CAPITALIZED (NOT USED)**		
		TOTAL	
15	**ACQUISITION OF BUILDINGS OR OTHER PROPERTY (NOT USED)**		
	15.a		
		TOTAL	
		TOTAL REGULATED USES OF FUNDS	$ 49,093,972
16	**Unregulated uses of Project Funds**		
	15.a	St. Joseph Purchase Price	$ 775,000
		TOTAL	**$ 775,000**
		TOTAL PROJECT COST	**$ 49,868,972**

X. 1120.140 - Economic Feasibility

D. Projected Operating Costs

The applicant shall provide the projected direct annual operating costs (in current dollars per equivalent patient day or unit of service) for the first full fiscal year at target utilization but no more than two years following project completion. Direct cost means the fully allocated costs of salaries, benefits and supplies for the service.

				On a Resident Day Basis		
				2013	2014	2015
			Days	74205	74205	74205
	2013	2014	2015			
Salaries	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Benefits	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Supplies	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

E. Total Effect of the Project on Capital Costs

The applicant shall provide the total projected annual capital costs (in current dollars per equivalent patient day) for the first full fiscal year at target utilization but no more than two years following project completion.

	2013	per day	2014	per day	2015	per day
Days	74205		74205		74205	
Depreciation	$1,636,466	$ 22.05	$ 1,636,466	$ 22.05	$ 1,636,466	$ 22.05
Interest	$2,379,850	$ 32.07	$ 2,370,850	$ 31.95	$ 2,358,850	$31.79
	Total	**$ 54.12**		**$ 54.00**		**$53.84**

	2013	2014	2015
Salaries -Fixed Labor	$ 1,250,502	$ 1,250,502	$ 1,250,502
Salaries-Variable Labor	$ 5,511,870	$ 5,511,870	$ 5,511,870
Total Salaries	[illegible]	[illegible]	[illegible]
Employee Benefits			
IMRF, FICA/Medicare, Health Insurance			
Workers' Comp, Unemployment			
0.00%			
Total Employee Benefits	[illegible]	[illegible]	[illegible]
Non-Labor Expenses			
Administrative Expenses			
Accounting/Payroll 53019	$ 18,833	$ 19,398	$ 19,980
Legal fees..54304	$ -	$ -	$ -
Postage 53021	$ 127	$ 131	$ 135
Consultants 53071	$ 9,430	$ 9,712	$ 10,004
IT User Fee..54412	$ 162,943	$ 167,832	$ 172,867
Refund of Collected Fees...54409	$ 120,450	$ 120,450	$ 120,450
Penalties & Judgements ..54499	$ 11,266	$ 11,604	$ 11,952
Management Expenses 54418	$ 209,345	$ 215,625	$ 222,094
Misc..54407	$ 311	$ 320	$ 330
Advertising-other 54344	$ 37,599	$ 38,727	$ 39,889
Advertising-personnel 54343	$ 3,230	$ 3,327	$ 3,427
Employment Agency Salary..53290	$ 500,000	$ 515,000	$ 530,450
Op Supplies..52250	$ 179,497	$ 184,882	$ 190,428
Op Supplies, Paper Products 52254	$ -	$ -	$ -
Office Supplies.. 52201	$ 6,123	$ 6,306	$ 6,496
Telephone..54320	$ 21,214	$ 21,850	$ 22,505
Cellular Phone..54338	$ 5,153	$ 5,307	$ 5,466
Educational Tmg 54402	$ 6,987	$ 7,197	$ 7,413
Conferences & Seminars 54000	$ 9,139	$ 9,413	$ 9,696
Dues/memberships 54401	$ 19,333	$ 19,913	$ 20,510
Books & Periodicals 52203	$ 726	$ 748	$ 770
Auto Allowance..54331			
Travel 54330	$ 7,005	$ 7,215	$ 7,432
Recognition Awards 54347	$ 1,929	$ 1,987	$ 2,047
Risk Mgmnt Svcs 54421	$ 251,892	$ 259,449	$ 267,232
Bad Debt Expense 54496	$ 33,453	$ 34,457	$ 35,491
Recovery of Bad Debt..54498	$ (179,243)	$ (184,620)	$ (190,159)
Charge for Late Payment 54497	$ -	$ -	$ -
Recovery of Contribution to Medicaid IGT			
Subtotal Administrative Expenses	[illegible]	[illegible]	[illegible]
Nursing Expenses			
Medical Services 53051	$ 61,402	$ 63,244	$ 65,142
Patient Services 54417	$ 21,285	$ 21,924	$ 22,582
Drugs 52206	$ 260,200	$ 260,200	$ 260,200
Medical Supplies 52205	$ 270,751	$ 278,873	$ 287,239
Medical Equip Rental..54395	$ 57,151	$ 58,866	$ 60,632
Oxygen..52204	$ 31,429	$ 32,372	$ 33,343
Disposables 52251	$ -	$ -	$ -
Incontinent Products..52330	$ 166,049	$ 171,030	$ 176,161
Subtotal Nursing Expenses	[illegible]	[illegible]	[illegible]
Dietary			
Food 52041	$ 436,853	$ 449,958	$ 463,457
Perishables 52042	$ -	$ -	$ -
Staples 52043	$ -	$ -	$ -
Supplements 52044	$ -	$ -	$ -
Misc Food 52049	$ -	$ -	$ -

Op Supply-Dishes 52253	$ -	$ -	$ -
[illegible]	[illegible]	[illegible]	[illegible]
Environmental Services			
Laundry			
Linen & bedding..52255	$ 20,867	$ 21,493	$ 22,138
Subtotal Laundry	**$ 20,867**	**$ 21,493**	**$ 22,138**
Housekeeping			
Op Supplies-Chemicals 52252	$ 39,415	$ 40,598	$ 41,816
Subtotal Housekeeping	**$ 39,415**	**$ 40,598**	**$ 41,816**
Maintenance			
Garbage Collection 54366	$ 20,031	$ 20,632	$ 21,251
Infectious Waste Collection 54369	$ 12,571	$ 12,948	$ 13,336
Pest control 54364	$ 1,632	$ 1,681	$ 1,731
Repairs 54372	$ 1,349	$ 1,390	$ 1,432
Other Equip..55112	$ -	$ -	$ -
Mech Equip Repair 54373	$ 31,369	$ 32,310	$ 33,279
Maintenance Supplies 52091	$ 14,334	$ 14,765	$ 15,207
Bldg/Grnds Maint 54377	$ 3,862	$ 3,977	$ 4,097
Bldg/Grnds Maint Supplies 52280	$ 1,595	$ 1,643	$ 1,692
Duplicating Equip Maint 54380	$ 3,136	$ 3,230	$ 3,327
Utilities-elec/gas 53600	$ 304,719	$ 319,955	$ 335,953
GPSD User Charge 54362	$ 25,576	$ 26,343	$ 27,134
Water 54363	$ 32,570	$ 33,548	$ 34,554
Auto Repair Maint 53301	$ 1,957	$ 2,016	$ 2,076
Gas & Oil Products 52101	$ -	$ -	$ -
Computer Equip Maint 53791	$ 13,993	$ 14,413	$ 14,846
Building Improvements..55107	$ 50,000	$ 51,500	$ 53,045
Non-Capital Equipment 52352	$ 7,400	$ 7,622	$ 7,851
Non-Capital Furniture 52353	$ -	$ -	$ -
Subtotal Maintenance	$ 526,095	$ 547,972	$ 570,811
[illegible]	[illegible]	[illegible]	[illegible]
Activities			
Activity supplies	$ 5,150	$ 5,305	$ 5,464
Alzheimers' activity supplies	$ -	$ -	$ -
Alzheimer's entertainment	$ -	$ -	$ -
Volunteer recognition	$ -	$ -	$ -
[illegible]	[illegible]	[illegible]	[illegible]
Rehab Program	$ 1	$ 1	$ 1
Physical Therapy -53251	$ 526,248	$ 542,035	$ 558,296
Occupational Therapy - 53252	$ 560,033	$ 576,834	$ 594,139
Speech Therapy - 53253	$ 338,567	$ 348,724	$ 359,186
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
Depreciation	$ 1,636,466	$ 1,636,466	$ 1,636,466
Interest Expense	$ 2,380,300	$ 2,370,850	$ 2,358,850
[illegible]	[illegible]	[illegible]	[illegible]

			Budget
1	**PREPLANNING COSTS**		
	1.a	MPA Business Model, Scoping, Budgeting	$ 333,126
	1.b	LDG/FA Programing	$ 97,439
	1.d	River City Const. Pre-construction Services	$ 120,000
		TOTAL	**$ 550,565**
2	**SITE SURVEY AND SOIL INVESTIGATION**		
	2.a	ALTA/Topographic Survey	$ 15,500
	2.b	Plat of Subdivision	$ 9,500
	2.c	LDG/H General Geotech Study	$ 15,100
	2.d	LDG/G Foundation Study	$ 6,200
	2.e	LDG/H Construction Observation	$ 15,000
		TOTAL	**$ 61,300**
3	**SITE PREPARATION**		
	3.a	2.2 Division 2 Existing Conditions (demolition)	$ 622,045
	3.b	2.1 Abatement	$ 650,000
	3.c	Division 2 Excavation and grading	$ 408,502
	3.d	Sanitary Sewer	$ 108,674
	3.e	Water	$ 186,092
	3.f	Storm Sewer	$ 293,563
	3.g	Gas	$ 10,542
	3.h	Electric Service	$ 142,058
	3.i	32.2 Site Concrete	$ 82,064
	3.j	32.1 Bituminous Paving	$ 637,246
	3.k	32.3 Landscaping	$ 182,543
	3.l	General Conditions	$ 152,252
	3.m	Insurance and bond	$ 33,018
	3.n	CM Fee	$ 116,317
		TOTAL	**$ 3,624,916**
4	**OFFSITE WORK**		
	4.a	Water Mains	$ 379,798
	4.b	General Conditions	$ 15,225
	4.c	Insurance and Bond	$ 3,753
	4.d	CM Fee	$ 13,293
		TOTAL	**$ 412,069**
5	**NEW CONSTRUCTION CONTRACTS**		
	5.a	3.1 Building Concrete	$ 1,808,045
	5.b	4.1 Masonry	$ 679,940
	5.c	5.1 Steel Fabrication	$ 2,314,144
	5.d	5.2 Steel Erection	$ 1,235,423
	5.e	6.1 General Works	$ 3,014,536
	5.f	7.1 Roofing	$ 1,399,378

Illinois Department of Public Health (IDPH)
Long-Term Care Facility Questionnaire for 2010

This is a formal request by IDPH for full, complete and accurate information as stated herein. This request is made under the authority of the Health Facilities Planning Act [20ILCS 3960/]. Failure to respond may result in sanctions including the following:

"A person subject to this Act who fails to provide information requested by the State Board or State Agency within 30 days of the a formal written request shall be fined an amount not to exceed $1,000 for each 30-day period, or fraction thereof, that the information is not received by the State Board or State Agency." [20 ILCS 3960/14.1(b)(6)]

This questionnaire is divided into several parts:

Part I
Information on your facility and facility utilization
THIS PART MUST BE REPORTED FOR CALENDAR YEAR 2010

Part II
Financial and Capital Expenditures data for your facility
THIS PART MUST BE REPORTED FOR THE MOST RECENT FISCAL YEAR AVAILABLE TO YOU

Part III
Immunization for Influenza and Pneumonia

Part IV
Older Adult Services Survey

The Long Term Care Questionnaire must be completed and submitted by March 1, 2011.

Facilities failing to submit this questionnaire within the required time frame will be reported to the Illinois Health Facilities and Services Review Board for its consideration of the imposition of sanctions mandated by the Act.

Please contact this office with any questions or concerns related to this survey. You may contact us by e-mail at DPH.FacilitySurvey@illinois.gov, or by telephone at 217-782-3516.

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Next > Save e-inquisite

EXHIBIT II

Illinois Department of Public Health (IDPH)
Long-Term Care Facility Questionnaire for 2010

Welcome to the IDPH Electronic Long Term Care Facility Questionnaire.
INSTRUCTIONS FOR COMPLETING THIS SURVEY

NOTE:
Validation rules have been set up for some items; if your responses do not meet the validation rules, or if you have not filled in some required fields, you will not be allowed to proceed to the next page.

Navigating and Saving:
There are 3 buttons at the bottom of each survey page except the last one.
'Next' takes you to the next page of the survey
'Back' returns you to the previous survey page.
'Save' saves work in progress if you need to stop before finishing.

YOU DO NOT NEED TO SAVE AFTER EACH PAGE.
ONLY SAVE IF YOU NEED TO STOP BEFORE COMPLETING THE SURVEY.

IMPORTANT:
When you save your work, the unfinished survey is stored on our server with a new, random address. You will be prompted to set a bookmark or Favorite in our web browser.
YOU MUST DO THIS; YOU CANNOT ACCESS YOUR SAVED FORM WITHOUT IT.
The link provided in your e-mail WILL NOT access the saved form, only a blank survey. When you are ready to continue, use the bookmark or favorite to open the form. You will be returned to the place where you left off.

Saving the form also allows you to send the link created to another person, if needed. Since the link is to a file saved on our survey system, all the other person needs is the link to access the saved form.

The Submit form button on the last page transmits your survey responses to our database. Once the survey has been submitted, no further access or changes are allowed. If you find that you have submitted the form with incomplete or incorrect information, contact this office immediately.

Thank you for your cooperation.
Please contact this office by telephone at 217/782-3516 or by Email to DPH.FacilitySurvey@illinois.gov with any questions.

Page 2 of 15

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Illinois Department of Public Health (IDPH)
Long-Term Care Facility Questionnaire for 2010

This survey has been customized for your facility based on information in the IDPH databases.
Please verify the information on this page.

Facility Information

Facility Name

BELWOOD NURSING HOME

Facility Address

6701 WEST PLANK ROAD

Facility City , IL **Facility Zip Code**

PEORIA, IL 61604 , IL 61604

Licensed Beds <Definitions> 300

Licensed Beds shown here for information. Do not change.

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Illinois Department of Public Health (IDPH)
Long-Term Care Facility Questionnaire for 2010
Part I - Facility and Utilization Data

Please read the instructions for each question for clarification to understand the nature of the necessary response. All numeric fields are pre-filled with zeroes. As appropriate, complete all questions with required data. Validation rules are included to assist you in entering accurate and consistent data throughout the Questionnaire. All row and columns asking for entry of a total value are compared to the sum of the row and/or column. If entered values do not conform to the validation rules, please verify and enter the correct values.

Question 1 - Is your facility designated as any of the following:
Use this link to acccess definitions: <Definitions>

- ☐ **Life Care Facility**
- ☐ **Continuing Care Retirement Community**

Question 2 - Indicate conditions that prevent admission to your facility. Check all that apply. At least one box must be checked. Please note that if None (No Restrictions) is checked, no other boxes should be checked. <Definitions>

☐ **Aggressive/Anti-Social**	☐ **Non-Mobile**
☑ **Chronic Alcoholism**	☐ **Other Government Recipient***
☑ **Developmentally Disabled**	☐ **Under 65 Years of Age**
☑ **Drug Addiction**	☐ **Unable to Self-Medicate**
☐ **Medicaid Recipient**	☑ **Ventilator Dependency**
☐ **Medicare Recipient**	☐ **Infectious Disease Requiring Isolation**
☑ **Mental Illness**	☐ **Other Restrictions**
☐ **Non-Ambulatory**	☐ **None (No Restrictions)**

* 'Other Government Recipient' includes individuals whose primary source of payment is Veterans Administration, County Boards, Community Aid Agencies, grants, CHAMPUS, CHAMP-VA, or other government-sponsored programs.

Question 3 - If your facility ownership requires a Registered Agent with the Illinois Secretary of State, indicate the name, address and telephone number of this person or company (must be an Illinois resident or company).

Name of Registered Agent:	
Address of Registered Agent	
City, State and Zip Code (plus Four):	
Telephone Number:	

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Illinois Department of Public Health (IDPH)
Long-Term Care Facility Questionnaire for 2010
Part I - Facility and Utilization Data

Question 4 - Please report the number of Full-Time Equivalent Employees (FTEs), paid directly by your facility. DO NOT report the number of hours worked. Use the first pay period in December 2010 to account for your employees.

Due to the broad range of services provided in LTC facilities, IDPH is leaving the definition of 'Other Healthcare Personnel' broad enough to include all categories of healthcare staff not covered in the six listed major categories of personnel.

EMPLOYMENT CATEGORIES	FULL TIME EQUIVALENTS (FTEs)
Administrators	1
Physicians	0
Director of Nursing	1
Registered Nurses	5
LPNs	34
Certified Aides	88
Other Health Personnel	0
Other Non-Health Personnel	65
Totals 194	194

Please indicate the number of hours in the work week for a full-time employee: 40

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Illinois Department of Public Health (IDPH)
Long-Term Care Facility Questionnaire for 2009
Part I - Facility and Utilization Data

Question 5 - Resident Information for December 31, 2010

Beds	1. Nursing Care	2. Sheltered	3. Total	
1.Licensed Beds - 12/31/2010	300	0	300	300
2.Peak Beds Set Up - 2010*	300	0	300	300
3.Peak Beds Occupied - 2010*	247	0	247	247
4.Beds Set Up - 12/31/2010	300	0	300	300
5.Beds Occupied - 12/31/2010	214	0	214	214

* PEAK BEDS SET UP is the highest number of beds setup and staffed for use at any time during the year.
PEAK BEDS OCCUPIED is the highest number of beds in use at any time during the year.
AVAILABLE BEDS will be calculated as "Licensed Beds less Beds Occupied on December 31, 2010" [20 ILCS 3960/13]

Males			
6. Under 18	0	0	0
7. 18 - 44	0	0	0
8. 45 - 59	1	0	1
9. 60 - 64	3	0	3
10. 65 - 74	8	0	8
11. 75 - 84	15	0	15
12. 85 & Over	17	0	17
13. Total Males	44	0	44
Females	44	0	44
14. Under 18	0	0	0
15. 18 - 44	0	0	0
16. 45 - 59	0	0	0
17. 60 - 64	2	0	2
18. 65 - 74	17	0	17
19. 75 - 84	47	0	47
20. 85 & Over	104	0	104
21. Total Females	170	0	170
	170	0	170
22. Total Residents	214	0	214
	214	0	214

	1. Nursing Care	2. Sheltered	3. Total
Patient Days for 2010	*Patient day values should be based on resident count for CALENDAR YEAR 2010.*		
23. Medicare Patient Days	7026	n/a	7026

24. Medicaid Patient Days	62843	n/a	62843
25. Other Public Pay Patient Days	0	0	0
26. Private Insurance Patient Days	0	0	0
27. Private Pay Patient Days	14116	0	14116
28. Charity Care* Patient Days	0	0	0
29. Total All Patient Days	83985	0	83985
Room Rates			
30. Private Room Rate	210	0	n/a
31. Shared Room Rate	190	0	n/a

Racial Group Each resident in your facility on the last day of the year should be accounted for and counted only once.

32.Asian	0	0	0
33.Amer. Indian/Nat. Alaskan	0	0	0
34.Black/African American	24	0	24
35.Hawaiian/Pacific Islander	0	0	0
36.White	190	0	190
37.Race Unknown	0	0	0
38.Total All Races	214	0	214

Ethnicity Each resident in your facility on the last day of the year should be accounted for and counted only once.

39.Hispanic or Latino	2	0	2
40.Not Hispanic or Latino	212	0	212
41.Ethnicity Unknown	0	0	0
42.Total All Ethnicity	214	0	214

Primary Payment Source*	**1. Nursing Care**	**2. Sheltered**	**3. Total**
43.Medicare	15	n/a	15
44.Medicaid	162	n/a	162
45.Other Public	0	0	0
46.Private Insurance	0	0	0
47.Private Pay	37	0	37
48.Charity Care	0	0	0
49.Total Residents	214	0	214

*"OTHER PUBLIC' includes all forms of direct public payment EXCLUDING Medicare and Medicaid. DMH/DD and Veterans Administration funds and other public funds paid directly to a facility should be recorded here.
'PRIVATE PAY' includes money from a private account AND any government funding made out and paid to the resident which is then transferred to the facility to pay for services.
'INSURANCE' refers to payment made through private insurance policies.
"Charity care" means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer. [20 ILCS 3960, Section 3] Charity care does not include bad debt or the unreimbursed cost of Medicare, Medicaid, and other federal, State, or local indigent health care programs, eligibility for which is based on financial need.

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https://survey.dph.illinois.gov/survey/cgi-bin/qwebcorporate.cgi?rq=resume&rid=INQ-20110223091122-... 2/23/2011

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Illinois Department of Public Health (IDPH)
Long-Term Care Facility Questionnaire for 2010
Part I - Facility and Utilization Data

Question 6 - Admissions and Discharges during the Calendar Year 2010.

Short-Term discharges to the hospital for Acute or Sub-Acute Care or releases to visit friends and relatives by residents who are expected to return to the facility are not to be counted as discharges or re-admissions. Count only those residents initially admitted and those permanently discharged from your facility. A resident who has been permanently discharged and later re-enters the facility may be counted as a new admission.

The sum of Lines A + B, minus Line C must equal Line D. The total number of residents recorded on Line D MUST NOT EXCEED the total number of licensed beds your facility has reported on Line 1 of QUESTION III. The total residents reported on line D must equal the total residents reported in Question IV and Question III, Lines 20a, 33, 37 and 44.

A. Residents on the FIRST DAY of the 2010. 245

Indicate the number of residents in your facility at the BEGINNING of the day on January 1, 2010 on Line A. The resident count should be the same as the resident count your facility reported to the Department on December 31, 2009.

B. Total Admissions DURING Calendar Year 2010. 146

Indicate the total number of residents your facility admitted during 2010 on Line B.

C. Total Discharges DURING Calendar Year 2010. 177

Indicate the total number of residents your facility discharged during 2010 on Line C. Remember, this value is final discharges only, not administrative discharges of any type.

D. Residents on the LAST DAY of 2010. 214

Indicate the total number of residents your facility had on December 31, 2010.

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Illinois Department of Public Health (IDPH)
Long-Term Care Facility Questionnaire for 2010
Part I - Facility and Utilization Data

Question 7 - Primary Diagnosis of Residents on DECEMBER 31, 2010.

Report the number of residents in your facility at the END OF THE LAST DAY OF 2010 by their PRIMARY diagnosis. COUNT ALL RESIDENTS - COUNT EACH RESIDENT ONLY ONCE. The primary diagnosis of a resident is the MAJOR health problem for which a resident is receiving care. Alongside each diagnostic group is the range of International Classification of Diseases codes contained within the particular diagnostic group. Use only the classifications listed – if a diagnosis does not fit into a listed classification include it in OTHER MEDICAL CONDITIONS.
NOTE: ALZHEIMER'S DISEASE – For the purpose of this questionnaire only – ALL RESIDENTS with a PRIMARY diagnosis of ALZHEIMER'S DISEASE are to be placed in the ICD-9 CODE 290.1 & 331.0.

ICD-9 CM Numbers	Primary Diagnosis	Number of Residents
140-239	Neoplasms	7
240-279	Endocrine/Metabolic Disorders	8
280-289	Blood Disorders	3
290.1 & 331.0	Alzheimer's Disease (All with Primary Diagnosis of Alzheimer's)	3
293-297,300	Mental Illness (Does not include Alzheimer's Disease)	0
299,315-319	Developmental Disabilities (Does not include Alzheimer's Disease)	0
320-389	Nervous System Disorders (Does not include Alzheimer's Disease)	10
390-459	Circulatory System Disorders	28
460-519	Respiratory System Disorders	13
520-579	Digestive System Disorders	8
580-629	Genitourinary System Disorders	14
680-709	Skin Disorders	5
710-739	Musculo-Skeletal Disorders	22
800-999	Injuries and Poisonings	44
	Other Medical Conditions	49
	Non-Medical Conditions	0
	Total Residents	214

Question 8 - Residents on December 31, 2010, whose Diagnosis Included Mental Illness.

Report the number of residents in your facility on December 31, 2010, whose diagnosis included Mental Illness (ICD-9 CODE 293-297.300). Include all the residents reported with Primary Diagnosis of Mental Illness in Question 7, and all residents with a diagnosis of Mental Illness in addition to their Primary Diagnosis.

Residents with Diagnosis of Mental Illness: 0

Question 9 - Residents on December 31, 2010, who were Identified Offenders*

Report the number of residents in your facility on December 31, 2010, who were categorized as Identified Offenders*.

Residents who were Identified Offenders: 2

* Any resident so identified through a criminal history background check as required by the Nursing Home Care Act (210 ILCS 45/2-201.5) paragraphs b and c.

Click 'Next' to proceed to Part II - Financial and Capital Expenditures Data

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Illinois Department of Public Health (IDPH)
Long-Term Care Facility Questionnaire for 2010
Part II - Financial & Capital Expenditures Data

THE DATA REQUESTED BY THIS QUESTIONNAIRE ARE AUTHORIZED PURSUANT TO THE ILLINOIS HEALTH FACILITIES PLANNING ACT [20 ILCS 3960/5.3]

We have made fundamental changes in the way we are collecting the data, intended to make responses easier and the data more accurate.

Part II - Financial and Capital Expenditures data for your facility MUST BE REPORTED FOR THE MOST RECENT FISCAL YEAR AVAILABLE TO YOU.
THESE DOLLAR AMOUNTS ARE FOUND IN YOUR MOST RECENT ANNUAL FINANCIAL STATEMENTS WHICH INCLUDES YOUR INCOME STATEMENT STATEMENT AND BALANCE SHEET.
FINANCIAL STATEMENTS ARE DEFINED AS AUDITED FINANCIAL STATEMENTS, REVIEW OR COMPILATION FINANCIAL STATEMENTS, OR TAX RETURN FOR THE MOST RECENT FISCAL YEAR AVAILABLE TO YOU.

If you have any problems providing the data requested, please contact this office by e-mail at DPH.FacilitySurvey@illinois.gov, or by telephone at 217-782-3516.

Indicate the Starting and Ending Dates of your Fiscal Year (mm/dd/yyyy)

Starting 01/01/2010 **Ending** 12/31/2010

Source of Financial Data Used

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Illinois Department of Public Health (IDPH)
Long-Term Care Facility Questionnaire for 2010
Part II - Financial & Capital Expenditures Data

A. CAPITAL EXPENDITURES

Provide the following information for all projects / capital expenditures IN EXCESS OF $293,500 obligated by or on behalf of the health care facility for your reported Fiscal Year (click the link below the table for definitions of terms):

	Description of Project / Capital Expenditure	Amount Obligated	Method of Financing	CON Project Number (if reviewed)
1.	Bel-Wood Reconstruction	$1,744,675	Operating Cash	N/A
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

<Definitions>

Report the TOTAL of ALL Capital Expenditures for your reported Fiscal Year (include expenditures below $293,500):

TOTAL CAPITAL EXPENDITURES FOR YOUR REPORTED FISCAL YEAR (including those below $293,500) 1,887,557

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Illinois Department of Public Health (IDPH)
Long-Term Care Facility Questionnaire for 2010
Part II - Financial & Capital Expenditures Data

B. NET REVENUES BY PAYMENT SOURCE FOR YOUR REPORTED FISCAL YEAR

	Fiscal Year Net Revenues
Medicare	3,315,047
Medicaid	8,297,324
Other Public Pay*	0
Private Insurance*	477,640
Private Payment*	1,841,947
TOTAL NET REVENUES FOR REPORTED FISCAL YEAR	13,931,958

* 'OTHER PUBLIC PAY' includes all forms of direct public payment EXCLUDING Medicare and Medicaid. DMH/DD and Veterans Administration funds and other public funds paid directly to a facility should be recorded here.
'PRIVATE INSURANCE' refers to payment made through private insurance policies.
'PRIVATE PAYMENT' includes money from a private account AND any government funding made out and paid to the resident which is then transferred to the facility to pay for services.

C. ACTUAL COST OF CHARITY CARE SERVICES PROVIDED IN YOUR REPORTED FISCAL YEAR

"Charity care" means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer. [20 ILCS 3960, Section 3]
Charity care does not include bad debt or the unreimbursed cost of Medicare, Medicaid, and other federal, State, or local indigent health care programs, eligibility for which is based on financial need.

	Amount
Actual Cost of Services Provided to Charity Care Residents in Reported Fiscal Year	0

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Illinois Department of Public Health (IDPH)
Long-Term Care Facility Questionnaire for 2010
Part III - Influenza/Pneumonia Vaccinations

The Immunization Section of the Illinois Department of Public Health requests that you provide the following information regarding the immunization policies and immunization status of your staff and residents in regards to influenza and pneumococcal pneumonia. Thank you.

	Yes	No
Does your facility have a written policy for administering influenza vaccine to RESIDENTS?	◉	○
Does your facility have a written policy for administering pneumococcal vaccine to RESIDENTS?	◉	○
Does your facility have a written policy for vaccinating STAFF MEMBERS against influenza?	○	◉
Does your facility have a written policy for vaccinating STAFF MEMBERS against pneumococcal pneumonia?	○	◉
Does your facility have a written policy for use of amantadine and/or rimantadine during an influenza outbreak?	○	◉

	Number Receiving Inluenza Vaccine	Number NOT Receiving Influenza Vaccine
Record the number of RESIDENTS who received influenza vaccine during the time period from October, 2010 through January, 2011	183	30

	Number Receiving Pneumococal Vaccine	Number NOT Receiving Pneumococal Vaccine
Record the number of CURRENT RESIDENTS who have received a pneumococcal vaccine in the years 2005 through 2010	170	43

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Illinois Department of Public Health (IDPH)
Long-Term Care Facility Questionnaire for 2010
Part IV - Older Adult Services Survey

The Older Adult Services Advisory Committee, created by Public Act 093-1031, is required to gather information about services being provided to older adults in the State of Illinois as part of its mandate to "promote a transformation of Illinois' comprehensive system of older adult services from funding a primarily facility-based service delivery system to primarily a home-based and community-based system, taking into account the continuing need for 24-hour skilled nursing care and congregate housing with services".

1. What outpatient or community based services to clients, other than your nursing home residents, does your facility or affiliated agency offer?

Outpatient/Community-Based Services.	Average Daily Number of Clients Served in the Previous Month
Outpatient Physical Therapy	
Outpatient Occupational Therapy	
Outpatient Speech Therapy	
In House Respite Care Program 24 Hours or More	
In House Respite Care Program Less than 24 Hours Per Day	
Adult Day Care Services Not Part of Respite Care Program	
Alzheimer's Adult Day Care Services Not Part of Respite Care Program	
Home Health Care for Medicare or Medicaid Clients	
Home Care Services for Private Pay Clients	
Homemakers and Personal Care Assistants	
Home Delivered Meals Program	
Transportation Services for Persons in the Community	
Outpatient Wound Care and/or Specialized Wound Care	
Outpatient Dialysis	
Community Family Caregiver Training or Support*	
Community Nutrition Site	
Outpatient Telephone Reassurance for Community Seniors	
Private Duty Nursing Services	

* For Community Members Other than Residents' Family Members

2. What Other Outpatient/Community Services Does Your Facility Offer?

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Illinois Department of Public Health (IDPH)
Long-Term Care Facility Questionnaire for 2010

Please provide the following contact information for the individual responsible for the preparation of this questionnaire:

Contact Person Name	BECKY POLHEMUS
Contact Person Job Title	Office Manager
Contact Person Telephone	309-697-4541
Contact Person E-Mail Address	bpolhemus@peoriacounty.org

Please provide the following information for the Facility Administrator/CEO of the facility:

Administrator's Name	Matthew Nieukirk
Administrator's Title	Administrator
Administrator Telephone	309-697-4541
Administrator E-Mail Address	mnieukirk@peoriacounty.org

THANK YOU FOR COMPLETING THE ON-LINE IDPH LONG-TERM CARE QUESTIONNAIRE.
If you have any comments on the survey, please enter them in the space below.

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Illinois Department of Public Health (IDPH)
Long-Term Care Facility Questionnaire for 2010

CERTIFICATION OF SURVEY DATA

Pursuant to the Health Facilities Planning Act (20 ILCS 3960/13), the State Board requires "all health facilities operating in the State to provide such reasonable reports at such times and containing such information as is needed" by the Board to carry out the purposes and provisions of this Act. By completing this section, the named individual is certifying that he/she has read the foregoing document, that he/she is authorized to make this certification on behalf of this facility, and that the information contained in this report is accurate, truthful and complete to the best of his/her knowledge and belief. Please note that the State Board will be relying on the information contained in this document as being truthful and accurate information. Any misrepresentations will be considered material.

☑ I certify that the information in this report is accurate, truthful and complete to the best of my knowledge.

Person Certifying: Matt Nieukirk

Job Title: Administrator

Certification Date: 02/23/2011

WE STRONGLY RECOMMEND THAT YOU PRINT OUT EACH PAGE OF THIS FORM WITH YOUR ANSWERS FOR FUTURE REFERENCE.

ONCE YOU HAVE SUBMITTED THE FORM, NO FURTHER ACCESS OR CHANGES ARE POSSIBLE.

YOU CANNOT RETRACT OR CHANGE A SUBMITTED FORM, SO BE SURE TO VERIFY YOUR ANSWERS BEFORE CLICKING ON THE 'SUBMIT FORM' BUTTON.

WHEN YOU HAVE REVIEWED AND PRINTED YOUR RESPONSES, CLICK THE 'SUBMIT FORM' BUTTON TO SEND YOUR COMPLETED QUESTIONNAIRE BACK TO OUR OFFICE. YOU WILL BE ROUTED TO A CONFIRMATION PAGE.

IF YOU HAVE ANY PROBLEMS, PLEASE CONTACT THIS OFFICE IMMEDIATELY AT 217-782-3516 OR BY EMAIL AT DPH.FACILITYSURVEY@ILLINOIS.GOV

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Patrick Urich
County Administrator

County of Peoria
County Administration
Peoria County Courthouse, Room 502
324 Main Street, Peoria, Illinois 61602
Phone (309) 672-6056 Fax (309) 672-6054 TDD (309) 672-6073
Web: www.peoriacounty.org

To: Health Facilities & Services Review Board

From: Patrick Urich
County Administrator

Date: March 24, 2011
Re: Replacement Facility
Bel-Wood Nursing Home
Charity Care

Consistent with the mission of Peoria County, Bel-Wood Nursing Home does not admit residents based on their ability to pay, nor has Bel-Wood ever discharged any resident because of ability to pay. Bel-Wood has always been committed to serving the Medicaid population and this element of the Peoria County mission will continue as the replacement Bel-Wood will be located in a market area that best serves the needs of Peoria County's Medicaid population. As a county-owned and operated nursing home, and as an administrative arm of state government, Bel-Wood is an integral component of the Medicaid system. Furthermore, Bel-Wood's role in the Medicaid system affords the State of Illinois the advantage of using Bel-Wood's Medicaid usage and cost data towards the State's federal Medicaid reimbursement match. The largest portion of Bel-Wood's revenues is Medicaid. Arguably, Bel-Wood has the largest Medicaid population of any nursing home in the Peoria MSA, even downstate Illinois. As a result, we are forecasting no change in Bel-Wood's revenue mix.

By: _____
Patrick Urich, County Administrator
Date: 3/24/11

Attest: _____
Notary Public
3/24/2011
My commission expires 2012

"OFFICIAL SEAL"
VIRGINIA PEARL
Notary Public, State of Illinois
My Commission Expires 08-24-2012

EXHIBIT III

Exhibit 8c

Bel-Wood Nursing Home
Forecast Income Statement

		Year 2015
Revenues		
Private Pay		
Routine	$	390,283
Alzheimer's	$	2,725,272
Hospice	$	156,113
Incontinence	$	19,734
Other Ancillary	$	523,553
Total Private Pay	$	3,814,955
Medicaid		
Routine	$	6,438,860
Hospice	$	260,487
Total Medicaid	$	6,699,347
Medicare		
Routine Part A	$	4,199,800
Medicare B	$	425,036
Total Medicare	$	4,624,836
Total Patient Service Revenues	$	15,139,138
Miscellaneous Revenues	$	150,000
Total Revenues	$	15,289,138
Expenses		
Salaries	$	6,762,373
Employee Benefits	$	676,237
Non-Labor Expenses		
Administrative Expenses	$	1,516,904
Nursing Expenses	$	905,298
Dietary	$	463,457
Environmental Services	$	634,765
Activities	$	5,464
Rehab Program	$	1,511,621
Direct County Pmts & Adjustments		
Supplies (MCC)		
Other (excluding employee benefits)		

EXHIBIT IV

Special Cost Centers (MCC)		
Total Non-Labor Expenses	$	5,037,568
Depreciation (MCC)	$	1,636,466
Interest, Replacement Facility	$	2,358,850
Total Expenses	$	16,471,434
Gain (Loss)	$	(1,182,296)
Net Income Before Levy	$	(1,182,296)
Annual County Levy	$	1,951,117
Net Income	$	768,822
Cash Available for Debt Service		
Net Income	$	818,822
Add back depreciation	$	1,636,466
Add back Interest	$	2,358,850
Total Cash Available for Debt Service	$	5,814,137
Debt Service		
Principal	$	500,000
Interest	$	2,358,850
Cash Required for Debt Service	$	2,858,850
Cash After Debt Service	$	1,955,287
Debt Service Coverage		1.68

BELWOOD NURSING HOME
6701 WEST PLANK ROAD
PEORIA, IL 61604
Reference Numbers Facility ID 6000814
Health Service Area 002 Planning Service Area 143
Administrator
Matt Neuhrk

Contact Person and Telephone
Becky Polhamus
309-697-4541

Date Completed
4/21/2009

Registered Agent Information
N/A

FACILITY OWNERSHIP
COUNTY

ADMISSION RESTRICTIONS

Aggressive/Anti-Social	0
Chronic Alcoholism	1
Developmentally Disabled	1
Drug Addiction	1
Medicaid Recipient	0
Medicare Recipient	0
Mental Illness	1
Non-Ambulatory	0
Non-Mobile	0
Public Aid Recipient	0
Under 65 Years Old	0
Unable to Self-Medicate	0
Ventilator Dependent	1
Infectious Disease w/ Isolation	0
Other Restrictions	0
No Restrictions	0

Note: Reported restrictions denoted by '1'

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS	
Neoplasms	6
Endocrine/Metabolic	6
Blood Disorders	5
*Nervous System Non Alzheimer	10
Alzheimer Disease	51
Mental Illness	0
Developmental Disability	0
Circulatory System	22
Respiratory System	1
Digestive System	3
Genitourinary System Disorders	3
Skin Disorders	3
Musculo-skeletal Disorders	40
Injuries and Poisonings	114
Other Medical Conditions	4
Non-Medical Conditions	0
TOTALS	268

LICENSED BEDS, BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS

LEVEL OF CARE	LICENSED BEDS	PEAK BEDS SET-UP	PEAK BEDS USED	BEDS SET-UP	BEDS IN USE	AVAILABLE BEDS	MEDICARE CERTIFIED	MEDICAID CERTIFIED
Nursing Care	300	300	268	300	268	32	50	300
Skilled Under 22	0	0	0	0	0	0		0
Intermediate DD	0	0	0	0	0	0		0
Sheltered Care	0	0	0	0	0	0		
TOTAL BEDS	300	300	268	300	268	32	50	300

ADMISSIONS AND DISCHARGES - 2008

Residents on 1/1/2008	271
Total Admissions 2008	240
Total Discharges 2008	243
Residents on 12/31/2008	268

FACILITY UTILIZATION - 2008
BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

LEVEL OF CARE	Medicare Pat. days	Medicare Occ. Pct.	Medicaid Pat. days	Medicaid Occ. Pct.	Other Public Pat. days	Private Insurance Pat. days	Private Pay Pat. days	Charity Care Pat. days	TOTAL Pat. days	Licensed Beds Occ. Pct.	Peak Beds Set Up Occ. Pct.
Nursing Care	8395	45.9%	70445	64.2%	0	0	18980	0	97820	89.1%	89.1%
Skilled Under 22			0	0.0%	0	0	0	0	0	0.0%	0.0%
Intermediate DD			0	0.0%	0	0	0	0	0	0.0%	0.0%
Sheltered Care					0	0	0	0	0	0.0%	0.0%
TOTALS	8395	45.9%	70445	64.2%	0	0	18980	0	97820	89.1%	89.1%

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2008

AGE GROUPS	NURSING CARE Male	NURSING CARE Female	SKL UNDER 22 Male	SKL UNDER 22 Female	INTERMED. DD Male	INTERMED. DD Female	SHELTERED Male	SHELTERED Female	TOTAL Male	TOTAL Female	GRAND TOTAL
Under 18	0	0	0	0	0	0	0	0	0	0	0
18 to 44	0	0	0	0	0	0	0	0	0	0	0
45 to 59	3	1	0	0	0	0	0	0	3	1	4
60 to 64	2	3	0	0	0	0	0	0	2	3	5
65 to 74	9	17	0	0	0	0	0	0	9	17	26
75 to 84	15	73	0	0	0	0	0	0	15	73	88
85+	30	115	0	0	0	0	0	0	30	115	145
TOTALS	59	209	0	0	0	0	0	0	59	209	268

EXHIBIT V

BELWOOD NURSING HOME
6701 WEST PLANK ROAD
PEORIA, IL 61604
Reference Numbers Facility ID 6000814
Health Service Area 002 Planning Service Area 143

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare	Medicaid	Other Public	Insurance	Private Pay	Charity Care	TOTALS
Nursing Care	23	193	0	0	52	0	268
Skilled Under 22	0	0	0	0	0	0	0
ICF/DD		0	0	0	0	0	0
Sheltered Care			0	0	0	0	0
TOTALS	23	193	0	0	52	0	268

AVERAGE DAILY PAYMENT RATES

LEVEL OF CARE	SINGLE	DOUBLE
Nursing Care	171	151
Skilled Under 22	0	0
Intermediate DD	0	0
Shelter	0	0

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	SklUnd22	ICF/DD	Shelter	Totals
Asian	0	0	0	0	0
Amer. Indian	0	0	0	0	0
Black	31	0	0	0	31
Hawaiian/Pac. Isl.	0	0	0	0	0
White	237	0	0	0	237
Race Unknown	0	0	0	0	0
Total	268	0	0	0	268

ETHNICITY	Nursing	SklUnd22	ICF/DD	Shelter	Totals
Hispanic	1	0	0	0	1
Non-Hispanic	267	0	0	0	267
Ethnicity Unknown	0	0	0	0	0
Total	268	0	0	0	268

STAFFING

EMPLOYMENT CATEGORY	FULL-TIME EQUIVALENT
Administrators	1.00
Physicians	0.00
Director of Nursing	1.00
Registered Nurses	6.00
LPN's	30.00
Certified Aides	100.00
Other Health Staff	0.00
Non-Health Staff	67.00
Totals	205.00

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	TOTALS	Charity Care Expense	Charity Care Expense as % of Total Net Revenue
17.7%	66.5%	0.0%	2.0%	13.5%	100.0%		0.0%
3,243,625	12,233,654	0	371,579	2,474,127	18,322,985	0	

BELWOOD NURSING HOME
6701 WEST PLANK ROAD
PEORIA, IL 61604
Reference Numbers Facility ID 6000614
Health Service Area 002 Planning Service Area 143

Administrator
Matthew Hesslink

Contact Person and Telephone
BECKY POLHEMUS
309-697-4341

Registered Agent Information

Date Completed
4/29/2010

FACILITY OWNERSHIP
COUNTY

CONTINUING CARE COMMUNITY No
LIFE CARE FACILITY No

ADMISSION RESTRICTIONS

Aggressive/Anti-Social	0
Chronic Alcoholism	1
Developmentally Disabled	1
Drug Addiction	1
Medicaid Recipient	0
Medicare Recipient	0
Mental Illness	1
Non-Ambulatory	0
Non-Mobile	0
Public Aid Recipient	0
Under 65 Years Old	0
Unable to Self-Medicate	0
Ventilator Dependent	1
Infectious Disease w/ Isolation	0
Other Restrictions	0
No Restrictions	0

Note: Reported restrictions denoted by '1'

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS	
Neoplasms	5
Endocrine/Metabolic	8
Blood Disorders	4
*Nervous System Non Alzheimer	12
Alzheimer Disease	40
Mental Illness	0
Developmental Disability	4
Circulatory System	25
Respiratory System	1
Digestive System	2
Genitourinary System Disorders	2
Skin Disorders	3
Musculo-skeletal Disorders	39
Injuries and Poisonings	89
Other Medical Conditions	1
Non-Medical Conditions	0
TOTALS	245

Total Residents Diagnosed as Mentally Ill 0

LICENSED BEDS, BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS

LEVEL OF CARE	LICENSED BEDS	PEAK BEDS SET-UP	PEAK BEDS USED	BEDS SET-UP	BEDS IN USE	AVAILABLE BEDS	MEDICARE CERTIFIED	MEDICAID CERTIFIED
Nursing Care	300	300	269	300	245	55	50	300
Skilled Under 22	0	0	0	0	0	0		0
Intermediate DD	0	0	0	0	0	0		0
Sheltered Care	0	0	0	0	0	0		
TOTAL BEDS	300	300	269	300	245	55	50	300

ADMISSIONS AND DISCHARGES - 2009

Residents on 1/1/2009	269
Total Admissions 2009	148
Total Discharges 2009	172
Residents on 12/31/2009	245
Identified Offenders	2

FACILITY UTILIZATION - 2009
BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

LEVEL OF CARE	Medicare Pat. days	Medicare Occ. Pct.	Medicaid Pat. days	Medicaid Occ. Pct.	Other Public Pat. days	Private Insurance Pat. days	Private Pay Pat. days	Charity Care Pat. days	TOTAL Pat. days	Licensed Beds Occ. Pct.	Peak Beds Set Up Occ. Pct.
Nursing Care	6123	33.6%	70216	64.1%	0	0	18659	0	94998	86.8%	86.8%
Skilled Under 22			0	0.0%	0	0	0	0	0	0.0%	0.0%
Intermediate DD			0	0.0%	0	0	0	0	0	0.0%	0.0%
Sheltered Care					0	0	0	0	0	0.0%	0.0%
TOTALS	6123	33.6%	70216	64.1%	0	0	18659	0	94998	86.8%	86.8%

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2009

AGE GROUPS	NURSING CARE Male	NURSING CARE Female	SKL UNDER 22 Male	SKL UNDER 22 Female	INTERMED. DD Male	INTERMED. DD Female	SHELTERED Male	SHELTERED Female	TOTAL Male	TOTAL Female	GRAND TOTAL
Under 18	0	0	0	0	0	0	0	0	0	0	0
18 to 44	0	0	0	0	0	0	0	0	0	0	0
45 to 59	3	0	0	0	0	0	0	0	3	0	3
60 to 64	1	2	0	0	0	0	0	0	1	2	3
65 to 74	10	15	0	0	0	0	0	0	10	15	25
75 to 84	12	63	0	0	0	0	0	0	12	63	75
85+	25	114	0	0	0	0	0	0	25	114	139
TOTALS	51	194	0	0	0	0	0	0	51	194	245

BELWOOD NURSING HOME
6701 WEST PLANK ROAD
PEORIA, IL 61604
Reference Numbers Facility ID 6000614
Health Service Area 002 Planning Service Area 143

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare	Medicaid	Other Public	Insurance	Private Pay	Charity Care	TOTALS
Nursing Care	16	179	0	0	50	0	245
Skilled Under 22	0	0	0	0	0	0	0
ICF/DD		0	0	0	0	0	0
Sheltered Care			0	0	0	0	0
TOTALS	16	179	0	0	50	0	245

AVERAGE DAILY PAYMENT RATES

LEVEL OF CARE	SINGLE	DOUBLE
Nursing Care	210	190
Skilled Under 22	0	0
Intermediate DD	0	0
Shelter	0	0

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	SkiUnd22	ICF/DD	Shelter	Totals
Asian	0	0	0	0	0
Amer. Indian	0	0	0	0	0
Black	25	0	0	0	25
Hawaiian/Pac. Isl.	0	0	0	0	0
White	220	0	0	0	220
Race Unknown	0	0	0	0	0
Total	245	0	0	0	245
ETHNICITY	Nursing	SkiUnd22	ICF/DD	Shelter	Totals
Hispanic	0	0	0	0	0
Non-Hispanic	245	0	0	0	245
Ethnicity Unknown	0	0	0	0	0
Total	245	0	0	0	245

STAFFING

EMPLOYMENT CATEGORY	FULL-TIME EQUIVALENT
Administrators	1.00
Physicians	0.00
Director of Nursing	1.00
Registered Nurses	7.00
LPN's	29.00
Certified Aides	84.00
Other Health Staff	0.00
Non-Health Staff	64.00
Totals	186.00

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	TOTALS	Charity Care Expense*	Charity Care Expense as % of Total Net Revenue
16.7%	66.7%	0.0%	1.9%	14.6%	100.0%		0.0%
2,999,851	11,957,028	0	340,640	2,616,393	17,913,912	0	

*Charity Expense does not include expenses which may be considered a community benefit.