

		FOR OHF USE					

LL1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

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.

<p>I. IDPH Facility ID Number: <u>0023093</u></p> <p>Facility Name: <u>BALLARD NURSING CENTER</u></p> <p>Address: <u>9300 BALLARD ROAD</u> <u>DES PLAINES</u> <u>60016</u> Number City Zip Code</p> <p>County: <u>COOK</u></p> <p>Telephone Number: <u>(847) 294-2300</u> Fax # <u>(847) 299-4012</u></p> <p>IDPA ID Number: <u>36-2897326</u></p> <p>Date of Initial License for Current Owners: <u>1/1/1997</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>BOB KAGDA</u> Telephone Number: <u>(847) 675-3585</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2003</u> to <u>12/31/2003</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>MARK PICK</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>VICE PRESIDENT</u></td> <td></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u></td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>BOB KAGDA</u> <u>PARTNER</u></td> <td></td> </tr> <tr> <td>(Firm Name & Address) <u>KRUPNICK BOKOR KAGDA & BROOKS, LTD</u> <u>3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124</u></td> <td></td> </tr> <tr> <td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td> <td></td> </tr> </table> <p align="right">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>MARK PICK</u>			(Title) <u>VICE PRESIDENT</u>		Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u>	(Date) _____	(Print Name and Title) <u>BOB KAGDA</u> <u>PARTNER</u>		(Firm Name & Address) <u>KRUPNICK BOKOR KAGDA & BROOKS, LTD</u> <u>3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124</u>		(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																								
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																																								
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County																																								
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																																								
	<input checked="" type="checkbox"/> "Sub-S" Corp.																																									
	<input type="checkbox"/> Limited Liability Co.																																									
	<input type="checkbox"/> Trust																																									
	<input type="checkbox"/> Other _____																																									
Officer or Administrator of Provider	(Signed) _____	(Date) _____																																								
	(Type or Print Name) <u>MARK PICK</u>																																									
	(Title) <u>VICE PRESIDENT</u>																																									
Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u>	(Date) _____																																								
	(Print Name and Title) <u>BOB KAGDA</u> <u>PARTNER</u>																																									
	(Firm Name & Address) <u>KRUPNICK BOKOR KAGDA & BROOKS, LTD</u> <u>3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124</u>																																									
	(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>																																									

Facility Name & ID Number BALLARD NURSING CENTER

0023093 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	231	Skilled (SNF)	231	84,315	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	231	TOTALS	231	84,315	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	3,366		17,682	21,048	8
9	SNF/PED					9
10	ICF	24,269	7,810		32,079	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,635	7,810	17,682	53,127	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.01%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

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

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

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

I. On what date did you start providing long term care at this location?
Date started 01/01/77

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 145 and days of care provided 14,238

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

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

Facility Name & ID Number **BALLARD NURSING CENTER** # **0023093** Report Period Beginning: **01/01/2003** Ending: **12/31/2003**

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	306,176	23,236	10,066	339,478		339,478		339,478		1
2	Food Purchase		216,244		216,244		216,244	(695)	215,549		2
3	Housekeeping	265,004	50,515		315,519		315,519		315,519		3
4	Laundry	83,647	24,877		108,524		108,524		108,524		4
5	Heat and Other Utilities			223,561	223,561		223,561		223,561		5
6	Maintenance	97,305		107,643	204,948		204,948		204,948		6
7	Other (specify):*			32,949	32,949		32,949		32,949		7
8	TOTAL General Services	752,132	314,872	374,219	1,441,223		1,441,223	(695)	1,440,528		8
	B. Health Care and Programs										
9	Medical Director			91,500	91,500		91,500		91,500		9
10	Nursing and Medical Records	3,508,509	149,497	266,802	3,924,808		3,924,808		3,924,808		10
10a	Therapy	1,418,288		31,250	1,449,538		1,449,538		1,449,538		10a
11	Activities	158,375	6,597		164,972		164,972		164,972		11
12	Social Services	94,766			94,766		94,766		94,766		12
13	Nurse Aide Training										13
14	Program Transportation			3,153	3,153		3,153		3,153		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	5,179,938	156,094	392,705	5,728,737		5,728,737		5,728,737		16
	C. General Administration										
17	Administrative	155,521		276,700	432,221		432,221	(26,700)	405,521		17
18	Directors Fees										18
19	Professional Services			247,806	247,806		247,806	9,782	257,588		19
20	Dues, Fees, Subscriptions & Promotions			91,350	91,350		91,350	(45,473)	45,877		20
21	Clerical & General Office Expenses	592,695	76,340	85,766	754,801		754,801	(57,318)	697,483		21
22	Employee Benefits & Payroll Taxes			947,289	947,289		947,289	(1,716)	945,573		22
23	Inservice Training & Education			9,678	9,678		9,678		9,678		23
24	Travel and Seminar			18,729	18,729		18,729	(3,547)	15,182		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			155,784	155,784		155,784		155,784		26
27	Other (specify):*							13,987	13,987		27
28	TOTAL General Administration	748,216	76,340	1,833,102	2,657,658		2,657,658	(110,985)	2,546,673		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,680,286	547,306	2,600,026	9,827,618		9,827,618	(111,680)	9,715,938		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	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	8,986
	REPAIRS & MAINTENANCE	1,080
		0
		10,066
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	74,460
	ELECTRICITY	90,951
	WATER	51,857
	CABLE TV - LOBBY	6,293
		0
		223,561
6	MAINTENANCE	
	GROUNDS MAINTENANCE	15,273
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	CONTRACTED BLDG MAINT	24,037
	EQUIPMENT MAINTENANCE & REPAIR	68,333
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	0
	FIRE SERVICE	0
		0
		0
		0
		107,643
7	OTHER	
	SCAVENGER & EXTERMINATOR	32,949
	SECURITY SERVICE	0
		0
		32,949
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	91,500
		91,500

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	253,178
	LABORATORY & XRAY EXPENSE	136
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	4,128
	PHARMACY CONSULTANT XVIII B 39-2	9,360
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B -2	0
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		266,802
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B __-2	31,250
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		31,250
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	0
		0
		0
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

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

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	3,153
		3,153
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	276,700
		276,700
18	DIRECTORS FEES	0
		0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	86,565
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	141,787
	MEDICARE CONSULTANT	19,454
		247,806
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	23,302
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	17,974
	EMPLOYEE WANT ADS XIX F	18,724
	CONTRIBUTIONS VI 20 XIX F	700
	DUES & SUBSCRIPTIONS XIX F	10,619
	LICENSES & PERMITS XIX F	14,164
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	3,497
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	2,370
		91,350
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	3,640
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	276
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	81,850
	MESSENGER SERVICE	0
		85,766

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	487,679
	UNEMPLOYMENT COMPENSATION XIX D	53,840
	WORKERS COMPENSATION INSURANCE XIX D	69,051
	HOSPITALIZATION INSURANCE XIX D	327,760
	EMPLOYEE BENEFITS - OTHER XIX D	7,243
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	1,716
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		947,289
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	9,678
		9,678
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	18,729
		0
		0
		18,729
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	0
		0
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	155,784
		155,784
27	OTHER	
	BAD DEBTS VI 24	0
		0
		0

GRAND TOTAL COLUMN 3 OTHER

2,600,026

Facility Name & ID Number

BALLARD NURSING CENTER

#0023093

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			110,379	110,379		110,379	426,975	537,354			30
31	Amortization of Pre-Op. & Org.			17,601	17,601		17,601		17,601			31
32	Interest			86,224	86,224		86,224	672,521	758,745			32
33	Real Estate Taxes							351,958	351,958			33
34	Rent-Facility & Grounds			1,261,000	1,261,000		1,261,000	(1,261,000)				34
35	Rent-Equipment & Vehicles			59,304	59,304		59,304		59,304			35
36	Other (specify):*											36
37	TOTAL Ownership			1,534,508	1,534,508		1,534,508	190,454	1,724,962			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,041,592	36,685	1,078,277		1,078,277		1,078,277			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			126,473	126,473		126,473		126,473			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		1,041,592	163,158	1,204,750		1,204,750		1,204,750			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,680,286	1,588,898	4,297,692	12,566,876		12,566,876	78,774	12,645,650			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 **BALLARD NURSING CENTER**

0023093

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF 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	116,402	30		9
10	Interest and Other Investment Income	(510)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(695)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(276)	21		18
19	Entertainment	(23,302)	20		19
20	Contributions	(4,197)	20		20
21	Owner or Key-Man Insurance	(1,716)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(17,974)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(60,589)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 7,143		\$	30

OHF 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	2	
		Amount	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)	71,631		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 71,631		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 78,774		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	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.		X	\$	38
39					39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44	Exceptional Care Program		X		44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BALLARD NURSING CENTER

ID# 0023093

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	MARKETING SALARIES	\$ (57,042)	21	1
2	TRANSPORTATION - STAFF	(3,547)	24	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	(60,589)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BALLARD NURSING CENTER# 0023093

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(695)	0	0	0	0	0	0	0	0	0	0	(695)	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	(695)	0	0	0	0	0	0	0	0	0	0	(695)	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	Nurse Aide 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	(26,700)	0	0	0	0	0	0	0	0	(26,700)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	8,250	1,532	0	0	0	0	0	0	0	0	9,782	19
20	Fees, Subscriptions & Promotions	(45,473)	0	0	0	0	0	0	0	0	0	0	(45,473)	20
21	Clerical & General Office Expenses	(57,318)	0	0	0	0	0	0	0	0	0	0	(57,318)	21
22	Employee Benefits & Payroll Taxes	(1,716)	0	0	0	0	0	0	0	0	0	0	(1,716)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(3,547)	0	0	0	0	0	0	0	0	0	0	(3,547)	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	13,987	0	0	0	0	0	0	0	0	13,987	27
28	TOTAL General Administration	(108,054)	8,250	(11,181)	0	(110,985)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(108,749)	8,250	(11,181)	0	(111,680)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BALLARD NURSING CENTER# 0023093

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	116,402	309,317	1,256	0	0	0	0	0	0	0	0	426,975	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(510)	673,031	0	0	0	0	0	0	0	0	0	672,521	32
33	Real Estate Taxes	0	351,958	0	0	0	0	0	0	0	0	0	351,958	33
34	Rent-Facility & Grounds	0	(1,261,000)	0	0	0	0	0	0	0	0	0	(1,261,000)	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	115,892	73,306	1,256	0	190,454	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)	7,143	81,556	(9,925)	0	78,774	45							

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ELI PICK	32.5	NA		BALLARD PARTNER	DES PLAINES	BUILDING OWNE
MOSHE PICK	35			PICK MGMT GROUP		MGMT CO
HADASSAH PICK	20					
SARAH FITTERMAN	10					
GLORIA PRUZAN	2.5					

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 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 RENT	\$ 1,261,000	BALLARD PARTNERS		\$	\$ (1,261,000)	1
2	V							2
3	V	19 ACCOUNTING FEES		" " "		8,250	8,250	3
4	V	30 DEPRECIATION		" " "		309,317	309,317	4
5	V	32 INTEREST		" " "		673,031	673,031	5
6	V	33 REAL ESTATE TAX		" " "		351,958	351,958	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,261,000			\$ 1,342,556	\$ * 81,556	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 MANAGEMENT FEES	\$ 276,700	PICK MANAGEMENT GROUP		\$	\$ (276,700)
16	V						
17	V	17 SALARIES		" "		250,000	250,000
18	V	19 DATA PROCESSING		" "		1,532	1,532
19	V	27 PAYROLL TAXES		" "		13,987	13,987
20	V	30 DEPRECIATION		" "		1,256	1,256
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 276,700			\$ 266,775	\$ * (9,925)

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

Facility Name & ID Number

BALLARD NURSING CENTER

#

0023093

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MOHE PICK	EXECUTIVE DIR	ADMINISTRATIV	35.00	NONE	40	100.00	SALARY	\$ 125,000	17-7	1
2	ELI PICK	EXECUTIVE DIR	ADMINISTRATIV	32.50	NONE	40	100.00	SALARY	125,000	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 250,000		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 **BALLARD NURSING CENTER**

0023093 Report Period Beginning: **01/01/2003** Ending: **2/31/2003**

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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

BALLARD NURSING CENTER

0023093

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		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	ALLFIRST		X	MORTGAGE	\$44,927.00	5/91	\$ 4,500,000	\$ 9,284,770	8/34	10.5000	\$ 673,031	1						
2												2						
3												3						
4												4						
5	TRI CARE		X					17,642				1,909	5					
Working Capital																		
6	NEW CENTURY		X	WORKING CAPITAL				1,350,828				74,895	6					
7	CAPITALIZE LEASE		X	EQUIPMENT				53,483				5,419	7					
8	INSURANCE FINANCING		X	INSURANCE								4,001	8					
9	TOTAL Facility Related				\$44,927.00		\$ 4,500,000	\$ 10,706,723			\$ 759,255	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 4,500,000	\$ 10,706,723			\$ 759,255	15						

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

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

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

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2002 report.		\$	353,500	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.)		\$	350,873	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(2,627)	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	358,000	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 \$ <u>3,415</u> For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	(3,415)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	351,958	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1998	352,039	8
	1999	355,679	9
	2000	360,457	10
	2001	346,499	11
	2002	350,873	12

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

THE PAYMENT ON LINE 2 APPLIES TO THE 2002 TAX BILL.

FOR OHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2002	\$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BALLARD NURSING CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0023093

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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 2002 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 2002.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>09-15-303-013-0000</u>	<u>NURSING HOME</u>	\$ <u>350,872.67</u>	\$ <u>350,872.67</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>350,872.67</u>	\$ <u>350,872.67</u>

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 & 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 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number BALLARD NURSING CENTER

0023093

Report Period Beginning:

01/01/2003 Ending:

12/31/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 770,000 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (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, nurse aide 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 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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	231	1991	1973	\$ 2,851,196	\$ 103,848	35	\$ 90,514	\$ (13,334)	\$ 1,186,781	4
5			1994	995,072	25,515	35	25,515		245,582	5
6			1994	986,459	25,294	35	25,294		230,808	6
7			1995	101,526	2,603	35	2,603		22,234	7
8										8
Improvement Type**										
9	VARIOUS		1980	2,955		20			2,955	9
10	VARIOUS		1981	11,619		20			11,619	10
11	VARIOUS		1982	17,413		20			17,413	11
12	VARIOUS		1984	3,536		20			3,536	12
13	VARIOUS		1985	8,040		20			8,040	13
14	VARIOUS		1986	18,668		20	983	983	17,201	14
15	VARIOUS		1987	42,109	722	20	1,003	281	42,109	15
16	VARIOUS		1988	15,834	350	20	373	23	14,830	16
17	VARIOUS		1990	4,990	158	20	250	92	3,438	17
18	VARIOUS		1991	155,172	7,257	20	8,760	1,503	109,230	18
19	VARIOUS		1992	54,689	1,274	20	2,734	1,460	31,243	19
20	VARIOUS		1993	1,571	50	20	77	27	828	20
21	HEATING COOLING SYSTEM		1996	2,312	59	20	116	57	880	21
22	INTERIOR SIGNS		1996	350	9	20	18	9	136	22
23	BUILDING IMPROVEMENT		1996	70,114	1,798	20	3,506	1,708	26,587	23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number **BALLARD NURSING CENTER**# **0023093**

Report Period Beginning:

01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	AIR SYSTEM BALANCE	1996	\$ 1,762	\$ 297	20	\$ 88	\$ (209)	\$ 667	37
38	MAV MOTOR REPLACEMENT	1996	2,000	51	20	100	49	758	38
39	INTERIOR SIGNS	1996	663	17	20	33	16	250	39
40	DRAPES	1996	616	16	20	31	15	235	40
41	COMP STATION CABLE	1996	2,566	66	20	128	62	971	41
42	HEAT AND COOLING SYSTEM	1997	2,999	77	20	150	73	950	42
43	SEWAGE PUMP	1997	2,498	64	20	125	61	833	43
44	CAULKING	1998	5,845	150	20	292	142	1,509	44
45	RENOVATION PATIOS	1998	6,134	157	20	307	150	1,689	45
46	A/C REPAIRS	1998	2,124	54	20	106	52	592	46
47	PARKING LOT	1998			20				47
48	ALARM SYSTEM	1998	2,500	64	20	125	61	740	48
49	SEWAGE PUMP	1998	2,498	64	20	125	61	750	49
50	A/C COUPLINGS	1998	2,905	74	20	145	71	822	50
51	PATIO FLOOR	1998	2,040	52	20	102	50	553	51
52	MOTOR	1998	1,544	40	20	77	37	449	52
53	SPRINKLER SYSTEM	1998	3,500	90	20	175	85	948	53
54	FAUCETS, COUPLINGS	1998	10,159	260	20	508	248	2,794	54
55	COMPRESSORS	1998	13,886	356	20	694	338	3,701	55
56	MEDICAL GAS PIPING	1999	124,600	3,195	20	6,230	3,035	29,593	56
57	ELECTRICAL WORK	1999	201,699	5,172	20	10,085	4,913	49,585	57
58	CHILLER REPLACEMENT	1999	76,355	1,958	20	3,818	1,860	17,817	58
59	AIR CARRIER	1999	693	18	20	35	17	143	59
60	CARPETING	1999	4,921	126	20	492	366	2,419	60
61	LOADING RAMP & PATIO	1999	127,175	3,261	20	6,359	3,098	30,205	61
62	SPRINKLER REPAIRS	1999	2,850	73	20	143	70	620	62
63	HEATING AND COOLING	1999	8,208	210	20	410	200	1,708	63
64	FLOW DEVICE OXYGEN	1999	1,760	45	20	88	43	411	64
65	ER GENER DESIGN	1999	11,614	298	20	568	270	2,840	65
66	DOOR CENSORS	1999	718	18	20	36	18	159	66
67	SIGNS	1999	18,235	468	20	912	444	4,256	67
68	METAL INCLOSURE	1999	934	24	20	47	23	188	68
69	PARKING AND AISLE PAVE	1999	65,443	1,678	20	3,272	1,594	15,071	69
70	TOTAL (lines 4 thru 69)		\$ 6,055,069	\$ 187,430		\$ 197,552	\$ 10,122	\$ 2,149,676	70

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

Facility Name & ID Number **BALLARD NURSING CENTER**# **0023093**

Report Period Beginning:

01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 6,055,069	\$ 187,430		\$ 197,552	\$ 10,122	\$ 2,149,676	1
2	NURSE CALL SYSTEM	1999	49,222	1,262	20	2,461	1,199	11,280	2
3	LOAD RAMP DESIGN	1999	14,368	368	20	718	350	3,411	3
4	DOOR LOCKS	1999	2,781	71	20	139	68	602	4
5	FIRE PANEL	1999	978	25	20	49	24	225	5
6	NURSE CALL SYSTEM	2000	49,221	1,262	20	2,461	1,199	9,434	6
7	KEYLESS ENTRY SYSTEM	2000	1,250	32	20	62	30	240	7
8	ELECTRICAL OUTLETS	2000	7,600	195	20	380	185	1,266	8
9	VENTILATION BOILER	2000	5,696	146	20	284	138	900	9
10	WEIL MCLAIN BOILER	2000	50,425	1,293	20	2,521	1,228	5,462	10
11	HOT WATER BOILER	2000	9,172	235	20	459	224	1,224	11
12									12
13	TELEPHONE SYSTEM	1999	83,381	2,138	20	4,169	2,031	47,249	13
14	TELEPHONE SYSTEM ENHANCEMENT	2000	1,716	44	10	172	128	688	14
15									15
16	PICK MGMT GROUP	1996	48,986	1,256	20		(1,256)	49,896	16
17									17
18	DIALYSIS SPACE/MEDICAL & GAS UPGRADES	2001	33,596	1,222	27.5	1,221	(1)	3,087	18
19	COOLING COIL REPLACEMENT	2001	24,604	894	27.5	895	1	2,275	19
20									20
21	BOILER	2002	49,501	1,800	20	2,475	675	3,713	21
22	VALVES/BOOSTER PUMP	2002	2,430	88	20	122	34	183	22
23	DIALYSIS ROOM	2002	89,870	3,268	20	4,494	1,226	6,741	23
24	REMOVE & REPAPER ROOM	2002	10,972	399	20	549	150	823	24
25	FLOORING/DRAPERIES	2002	27,204	6,094	20	1,360	(4,734)	3,268	25
26									26
27	ELEV CAB REPLACEMENT	2003	6,850	114	27.5	114		114	27
28	REPAIR FLUE / REMOVE & REPLACE GREASE TRAP	2003	12,463	208	27.5	208		208	28
29	BLINDS	2003	1,760	29	27.5	29		29	29
30	REPAIR AIR HANDLER/REPLACE DIGITAL THERMOSTAT	2003	5,690	95	27.5	95		95	30
31	DOORS	2003	1,387	23	27.5	23		23	31
32	SIDEWALK REPAIRS	2003	800	14	27.5	14		14	32
33	HOT WATER BOILER	2003	29,001	835	27.5	835		835	33
34	TOTAL (lines 1 thru 33)		\$ 6,675,993	\$ 210,840		\$ 223,861	\$ 13,021	\$ 2,302,961	34

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

Facility Name & ID Number **BALLARD NURSING CENTER**

0023093

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 182,802	\$ 18,314	\$ 18,280	\$ (34)	10 YRS	\$ 43,417	71
72	Current Year Purchases	457,909	91,582	45,791	(45,791)	10 YRS	45,791	72
73	Fully Depreciated Assets	108,476				10 YRS	108,476	73
74	RELATED PARTY	2,494,216	100,216	249,422	149,206		692,517	74
75	TOTALS	\$ 3,243,403	\$ 210,112	\$ 313,493	\$ 103,381		\$ 890,201	75

D. Vehicle Depreciation (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)	\$ 9,919,396	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 420,952	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 537,354	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 116,402	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,193,162	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		\$ 18,390	92
93			93
94			94
95		\$ 18,390	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions				_____			4
5					_____			5
6					_____			6
7	TOTAL				\$ _____			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ 59,304 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2004 \$ _____

13. _____ /2005 \$ _____

14. _____ /2006 \$ _____

* 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.

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

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

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p><u>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</u></p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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	Nurse Aide 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 aides from other facilities.

\$

D. NUMBER OF AIDES 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 aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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

	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	\$		\$ 10,356	\$		\$ 10,356	1
2	Licensed Speech and Language Development Therapist		hrs			10,957			10,957	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			15,372			15,372	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts				335,863		335,863	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):						705,729		705,729	13
14	TOTAL			\$		\$ 36,685	\$ 1,041,592		\$ 1,078,277	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 nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number BALLARD NURSING CENTER

0023093

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2003

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>102,735</u>)	3,021,634		3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	226,311		6
7	Other Prepaid Expenses	115,951		7
8	Accounts Receivable (owners or related parties)	633,778		8
9	Other(specify): _____			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,997,674	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	28,950		15
16	Equipment, at Historical Cost	749,187		16
17	Accumulated Depreciation (book methods)	(371,770)		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 (spec CONSTR	18,390		22
23	Other(specify): <u>LEASE & SECURITY DEPOSIT</u>	18,678		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 443,435	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,441,109	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,477,141	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	33,917		28
29	Short-Term Notes Payable	1,458,253		29
30	Accrued Salaries Payable	419,995		30
31	Accrued Taxes Payable (excluding real estate taxes)	21,271		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	_____			36
37	_____			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,410,577	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,036,884		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)	\$ 1,036,884	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,447,461	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (6,352)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,441,109	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (17,277)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (17,277)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	10,925	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)	\$ 10,925	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)	\$ (6,352)	24 *

* This must agree with page 17, line 47.

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 11,698,613	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,698,613	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	856,672	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 856,672	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	8,442	13
14	Non-Patient Meals	2,433	14
15	Telephone, Television and Radio	6,075	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)	\$ 16,950	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	510	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 510	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING COMMISSIONS - NET	2,456	28
28a	MISC. INCOME	2,600	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 5,056	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,577,801	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,441,223	31
32	Health Care	5,728,737	32
33	General Administration	2,657,658	33
	B. Capital Expense		
34	Ownership	1,534,508	34
	C. Ancillary Expense		
35	Special Cost Centers	1,078,277	35
36	Provider Participation Fee	126,473	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,566,876	40
41	Income before Income Taxes (line 30 minus line 40)**	10,925	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 10,925	43

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

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

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

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

Facility Name & ID Number **BALLARD NURSING CENTER**

0023093

Report Period Beginning: **01/01/2003**

Ending:

12/31/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,202	1,422	\$ 164,326	\$ 115.56	1
2	Assistant Director of Nursing					2
3	Registered Nurses	39,214	42,532	1,260,729	29.64	3
4	Licensed Practical Nurses	39,289	46,426	518,077	11.16	4
5	Nurse Aides & Orderlies	110,541	119,709	1,540,876	12.87	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	30,546	33,206	1,332,030	40.11	7
8	Rehab/Therapy Aides	1,722	1,726	86,258	49.98	8
9	Activity Director	1,853	2,086	31,620	15.16	9
10	Activity Assistants	12,356	13,153	126,755	9.64	10
11	Social Service Workers	5,572	6,043	94,766	15.68	11
12	Dietician					12
13	Food Service Supervisor	3,615	3,968	67,765	17.08	13
14	Head Cook	1,786	2,016	21,273	10.55	14
15	Cook Helpers/Assistants	18,553	20,222	145,767	7.21	15
16	Dishwashers	9,089	9,707	71,371	7.35	16
17	Maintenance Workers	4,454	4,976	97,305	19.55	17
18	Housekeepers	35,262	37,018	265,004	7.16	18
19	Laundry	7,975	8,792	83,647	9.51	19
20	Administrator	642	663	33,911	51.15	20
21	Assistant Administrator	2,029	2,086	121,610	58.30	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	34,177	36,882	592,695	16.07	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,280	2,395	24,501	10.23	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	362,157	395,028	\$ 6,680,286 *	\$ 16.91	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	7,105	\$ 8,986	1-3	35
36	Medical Director	5,651	91,500	9-3	36
37	Medical Records Consultant	5,633	4,128	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	5,643	9,360	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant		0	11-3	44
45	Social Service Consultant		0	12-3	45
46	Other(specify)				46
47	<u>REHABILITATION CONSULTANT</u>	5,083	31,250	10a-3	47
48					48
49	TOTAL (lines 35 - 48)	29,115	\$ 145,224		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	2,941	\$ 147,156	10-3	50
51	Licensed Practical Nurses	2,779	106,022	10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)	5,720	\$ 253,178		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
JUDY PITZELE	ADMIN		\$ 33,911	Workers' Compensation Insurance	\$ 69,051	IDPH License Fee	\$ 8,110	
SUE MIKALS	ASST ADMIN		121,610	Unemployment Compensation Insurance	53,840	Advertising: Employee Recruitment	18,724	
				FICA Taxes	487,679	Health Care Worker Background Check	2,370	
				Employee Health Insurance	327,760	(Indicate # of checks performed <u>198</u>)		
				Employee Meals	#REF!	MARKETING/ADV/PROMO	41,276	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	4,197	
				EMPLOYEE BENEFITS - OTHER	7,243	LICENSES & PERMITS	6,054	
				EMPLOYEE PHYSICAL EXAMS	0	DUES & SUBSCRIPTIONS	10,619	
				PENSION/PROFIT SHARING PLANS	0	MGMT CO ALLOCATION		
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(4,197)	
				INSURANCE - EXECUTIVE LIFE	1,716	Less: Public Relations Expense	(23,302)	
				INSURANCE - EXECUTIVE LIFE VI 21	(1,716)	Non-allowable advertising	(17,974)	
						Yellow page advertising	(0)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 155,521	TOTAL (agree to Schedule V, line 22, col.8)	\$ #REF!	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 45,877	
B. Administrative - Other			E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount
MANAGEMENT FEES			\$ 276,700				Out-of-State Travel	\$
							In-State Travel	18,729
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 276,700				Seminar Expense	0
C. Professional Services								
Vendor/Payee	Type		Amount					
			\$				Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 18,729
SEE SCHEDULE ATTACHED			247,806	TOTAL		\$		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 247,806					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number **BALLARD NURSING CENTER**# **0023093**Report Period Beginning: **01/01/2003**Ending: **12/31/2003****XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. ILL COUNC ON LONG TERM CARE \$9670
- (3) Did the nursing home make political contributions or payments to a political 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. \$ 7,639 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 _____ 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 of Public Aid during this cost report period. \$ 126,473
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 of Public Aid, 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. \$ #REF! Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 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. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees