

Facility Name & ID Number BALLARD NURSING CENTER

0023093 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	17,963	6,845	21,858	46,666	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,963	6,845	21,858	46,666	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 55.35%

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

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

NONE

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

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

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 14,572

Medicare Intermediary ADMINASTAR

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number **BALLARD NURSING CENTER** # **0023093** Report Period Beginning: **01/01/2006** Ending: **12/31/2006**

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	349,809	26,992	14,480	391,281		391,281	0	391,281		1
2	Food Purchase		223,070		223,070	0	223,070	(13,585)	209,485		2
3	Housekeeping	298,764	55,665	0	354,429		354,429	0	354,429		3
4	Laundry	87,720	28,198	0	115,918	0	115,918	0	115,918		4
5	Heat and Other Utilities			261,459	261,459		261,459	0	261,459		5
6	Maintenance	60,218	115,152	31,038	206,408		206,408	0	206,408		6
7	Other (specify):*			22,915	22,915		22,915	0	22,915		7
8	TOTAL General Services	796,511	449,077	329,892	1,575,480	0	1,575,480	(13,585)	1,561,895		8
	B. Health Care and Programs										
9	Medical Director	0		104,300	104,300		104,300	0	104,300		9
10	Nursing and Medical Records	3,742,853	221,143	117,280	4,081,276	32,762	4,114,038	0	4,114,038		10
10a	Therapy	1,876,188		30,000	1,906,188		1,906,188	0	1,906,188		10a
11	Activities	141,832	8,721	1,280	151,833		151,833	0	151,833		11
12	Social Services	119,500		3,426	122,926		122,926	0	122,926		12
13	CNA Training			0	0		0	0	0		13
14	Program Transportation			169	169		169	0	169		14
15	Other (specify):*				0		0	0	0		15
16	TOTAL Health Care and Programs	5,880,373	229,864	256,455	6,366,692	32,762	6,399,454	0	6,399,454		16
	C. General Administration										
17	Administrative	291,650		257,550	549,200		549,200	(18,800)	530,400		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			207,928	207,928	(32,762)	175,166	(26,185)	148,981		19
20	Dues, Fees, Subscriptions & Promotions			135,762	135,762		135,762	(105,004)	30,758		20
21	Clerical & General Office Expenses	648,161	69,035	68,419	785,615		785,615	(302,457)	483,158		21
22	Employee Benefits & Payroll Taxes			1,204,566	1,204,566	0	1,204,566	(1,716)	1,202,850		22
23	Inservice Training & Education			12,057	12,057		12,057	0	12,057		23
24	Travel and Seminar			0	0		0	0	0		24
25	Other Admin. Staff Transportation			25,347	25,347		25,347	(1,382)	23,965		25
26	Insurance-Prop.Liab.Malpractice			328,503	328,503		328,503	0	328,503		26
27	Other (specify):*			207,587	207,587		207,587	(192,101)	15,486		27
28	TOTAL General Administration	939,811	69,035	2,447,719	3,456,565	(32,762)	3,423,803	(647,645)	2,776,158		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,616,695	747,976	3,034,066	11,398,737	0	11,398,737	(661,230)	10,737,507		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	14,480
	REPAIRS & MAINTENANCE	0
		0
		14,480
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	104,049
	ELECTRICITY	88,352
	WATER	62,962
	CABLE TV - LOBBY	6,096
		0
		261,459
6	MAINTENANCE	
	GROUNDS MAINTENANCE	10,664
	PAINTING & DECORATING	1,943
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	0
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	5,367
	FIRE SERVICE	0
	CONTRACTED BUILDING MAINTENANCE	13,064
		0
		0
		0
		31,038
7	OTHER	
	SCAVENGER	22,915
	SECURITY SERVICE	0
		0
		0
		22,915
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	104,300
		104,300

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	107,356
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	4,224
	PHARMACY CONSULTANT XVIII B 39-2	5,700
	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
		117,280
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	30,000
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		30,000
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	1,280
		0
		1,280
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	3,426
		0
		3,426
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	169
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	257,550
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	46,008
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	161,920
		0
		207,928
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	4,652
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	97,527
	EMPLOYEE WANT ADS XIX F	4,839
	CONTRIBUTIONS VI 20 XIX F	1,300
	DUES & SUBSCRIPTIONS XIX F	15,185
	LICENSES & PERMITS XIX F	9,504
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	160
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	210
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	1,155
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,230
	PATIENT BACKGROUND CHECKS XIX F	0
		135,762
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	29,199
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	3,537
	PENALTIES / OVERDRAFT CHARGES VI 18	7,830
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	27,853
	MESSENGER SERVICE	0
		0
		68,419

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	555,641
	UNEMPLOYMENT COMPENSATION XIX D	82,384
	WORKERS COMPENSATION INSURANC XIX D	102,347
	HOSPITALIZATION INSURANCE XIX D	453,754
	EMPLOYEE BENEFITS - OTHER XIX D	8,724
	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
		0
		1,204,566
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	12,057
		12,057
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	25,347
		25,347
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	328,503
		328,503
27	OTHER	
	BAD DEBTS VI 24	207,587
		207,587

GRAND TOTAL COLUMN 3 OTHER

3,034,066

BALLARD NURSING CENTER
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
 12/31/2006

TOTAL FOOD PURCHASE	223,070	PATIENT MEALS	139998
LESS SALES TAX	706	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	223,776	TOTAL MEALS/YEAR	139998
TOTAL PATIENT CENSUS	46,666	NET FOOD	223776
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	139998

TOTAL PATIENT MEALS	139998	COST PER MEAL	1.6
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number

BALLARD NURSING CENTER

#0023093

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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			208,938	208,938		208,938	147,037	355,975			30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0			31
32	Interest			221,073	221,073		221,073	911,414	1,132,487			32
33	Real Estate Taxes				0		0	386,504	386,504			33
34	Rent-Facility & Grounds			1,200,900	1,200,900		1,200,900	(1,200,900)	0			34
35	Rent-Equipment & Vehicles			39,625	39,625		39,625	0	39,625			35
36	Other (specify):*				0		0	0	0			36
37	TOTAL Ownership			1,670,536	1,670,536	0	1,670,536	244,055	1,914,591			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		1,554,365	239,206	1,793,571		1,793,571	0	1,793,571			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			126,473	126,473		126,473	0	126,473			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	1,554,365	365,679	1,920,044	0	1,920,044	0	1,920,044			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,616,695	2,302,341	5,070,281	14,989,317	0	14,989,317	(417,175)	14,572,142			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:

01/01/2006

Ending:

12/31/2006

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	(12,879)	2		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	(88,118)	30		9
10	Interest and Other Investment Income	(6,115)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(706)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(210)	20		17
18	Fines and Penalties	(7,830)	21		18
19	Entertainment	(4,652)	20		19
20	Contributions	(2,455)	20		20
21	Owner or Key-Man Insurance	(1,716)	22		21
22	Special Legal Fees & Legal Retainers	(32,762)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(207,587)	27		24
25	Fund Raising, Advertising and Promotional	(97,527)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(160)	20		28
29	Other-Attach Schedule	(296,009)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (758,726)		\$ 0	30

BHF USE ONLY					
48		49		50	
				51	
					52

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

		1	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)	341,551		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 341,551		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (417,175)		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: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	MARKETING SALARY	\$ (294,627)	21	1
2	MARKETING TRAVEL	(1,382)	25	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	(296,009)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BALLARD NURSING CENTER# 0023093

Report Period Beginning:

01/01/2006

Ending:

12/31/2006**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	(13,585)	0	0	0	0	0	0	0	0	0	0	(13,585)	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	(13,585)	0	0	0	0	0	0	0	0	0	0	(13,585)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(18,800)	0	0	0	0	0	0	0	0	0	(18,800)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(32,762)	6,577	0	0	0	0	0	0	0	0	0	(26,185)	19
20	Fees, Subscriptions & Promotions	(105,004)	0	0	0	0	0	0	0	0	0	0	(105,004)	20
21	Clerical & General Office Expenses	(302,457)	0	0	0	0	0	0	0	0	0	0	(302,457)	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	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(1,382)	0	0	0	0	0	0	0	0	0	0	(1,382)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(207,587)	15,486	0	0	0	0	0	0	0	0	0	(192,101)	27
28	TOTAL General Administration	(650,908)	3,263	0	(647,645)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(664,493)	3,263	0	(661,230)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BALLARD NURSING CENTER

0023093

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	(88,118)	235,155	0	0	0	0	0	0	0	0	0	147,037	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,115)	917,529	0	0	0	0	0	0	0	0	0	911,414	32
33	Real Estate Taxes	0	386,504	0	0	0	0	0	0	0	0	0	386,504	33
34	Rent-Facility & Grounds	0	(1,200,900)	0	0	0	0	0	0	0	0	0	(1,200,900)	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	(94,233)	338,288	0	244,055	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)	(758,726)	341,551	0	(417,175)	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 PARTNERS		BUILDING OWNER
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	\$ 1,200,900	BALLARD PARTNERS	100.00%	\$	\$ (1,200,900)	1
2	V							2
3	V	19 ACCOUNTING FEES		" " "		5,000	5,000	3
4	V	30 DEPRECIATION		" " "		235,155	235,155	4
5	V	32 INTEREST		" " "		917,529	917,529	5
6	V	33 REAL ESTATE TAX		" " "		386,504	386,504	6
7	V							7
8	V	17 MANAGEMENT FEES	257,550	PICK MAMAGEMENT GROUP			(257,550)	8
9	V							9
10	V	17 SALARIES		" " "		238,750	238,750	10
11	V	19 DATA PROCESSING		" " "		1,577	1,577	11
12	V	27 PAYROLL TAXES		" " "		15,486	15,486	12
13	V							13
14	Total		\$ 1,458,450			\$ 1,800,001	\$ * 341,551	14

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

Facility Name & ID Number

BALLARD NURSING CENTER

#

0023093

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	\$ 119,375	17-7	1
2	ELI PICK	EXECUTIVE DIR	ADMINISTRATIV	32.50	NONE	40	100.00	SALARY	119,375	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	\$ 238,750		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: **01/01/2006** Ending: **2/31/2006**

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:

01/01/2006

Ending:

12/31/2006

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	M&T REALTY CAPITAL CORP		X	MORTGAGE	\$99,200.00	9/25/06	\$ 9,592,200	\$ 9,592,200	9/25/41	5.8200	\$ 917,529	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6	NEW CENTURY BANK		X	WORKING CAPITAL				4,303,578			191,434	6						
7	VARIOUS		X	CAPITAL LEASES				304,303			23,092	7						
8			X	INSURANCE FINANCING							6,547	8						
9	TOTAL Facility Related				\$99,200.00		\$ 9,592,200	\$ 14,200,081			\$ 1,138,602	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$ 0	\$ 0			\$ 0	14						
15	TOTALS (line 9+line14)						\$ 9,592,200	\$ 14,200,081			\$ 1,138,602	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A 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 2005 report.	\$	361,000	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.)	\$	370,004	2
3. Under or (over) accrual (line 2 minus line 1).	\$	9,004	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	377,500	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	386,504	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	346,499	8
	2002	350,873	9
	2003	350,950	10
	2004	353,645	11
	2005	370,004	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2005	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

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 2005 TAX BILL.

NOTES:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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 Bureau of Health Finance at (217) 782-1630.

2005 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 2005 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 2005.

(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>370,004.10</u>	\$ <u>370,004.10</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>370,004.10</u>	\$ <u>370,004.10</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 original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number BALLARD NURSING CENTER

0023093

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ 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, CNA training facilities, etc.)
 List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$ 0	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 BHF 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	\$ 94,212	35	\$ 90,514	\$ (3,698)	\$ 1,458,323	4
5			1994	995,072	25,515	35	25,515		322,127	5
6			1994	986,459	25,294	35	25,294		306,690	6
7			1995	101,526	2,603	35	2,603		30,043	7
8										8
	Improvement Type**									
9	VARIOUS		1980	2,955	0	20	0		2,955	9
10	VARIOUS		1981	11,619	0	20	0		11,619	10
11	VARIOUS		1982	17,413	0	20	0		17,413	11
12	VARIOUS		1984	3,536	0	20	0		3,536	12
13	VARIOUS		1985	8,040	0	20	0		8,040	13
14	VARIOUS		1986	18,668	0	20	0		18,668	14
15	VARIOUS		1987	42,109	722	20	0	(722)	42,109	15
16	VARIOUS		1988	15,834	350	20	258	(92)	15,834	16
17	VARIOUS		1990	4,990	158	20	250	92	4,188	17
18	VARIOUS		1991	155,172	3,003	20	7,759	4,756	134,509	18
19	VARIOUS		1992	54,689	1,274	20	2,734	1,460	39,445	19
20	VARIOUS		1993	1,571	50	20	77	27	1,059	20
21	HEATING COOLING SYSTEM		1996	2,312	59	20	116	57	1,228	21
22	INTERIOR SIGNS		1996	350	9	20	18	9	190	22
23	BUILDING IMPROVEMENT		1996	70,114	1,798	20	3,506	1,708	37,105	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:

01/01/2006 Ending: 12/31/2006

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	
37	AIR SYSTEM BALANCE	1996	\$ 1,762	\$ 297	20	\$ 88	\$ (209)	\$ 931	37
38	MAV MOTOR REPLACEMENT	1996	2,000	51	20	100	49	1,058	38
39	INTERIOR SIGNS	1996	663	17	20	33	16	349	39
40	DRAPES	1996	616	16	20	31	15	328	40
41	COMP STATION CABLE	1996	2,566	66	20	128	62	1,355	41
42	HEAT AND COOLING SYSTEM	1997	2,999	77	20	150	73	1,400	42
43	SEWAGE PUMP	1997	2,498	64	20	125	61	1,208	43
44	CAULKING	1998	5,845	150	20	292	142	2,385	44
45	RENOVATION PATIOS	1998	6,134	157	20	307	150	2,610	45
46	A/C REPAIRS	1998	2,124	54	20	106	52	910	46
47	PARKING LOT	1998			20			1,115	47
48	ALARM SYSTEM	1998	2,500	64	20	125	61	1,125	48
49	SEWAGE PUMP	1998	2,498	64	20	125	61	1,257	49
50	A/C COUPLINGS	1998	2,905	74	20	145	71	859	50
51	PATIO FLOOR	1998	2,040	52	20	102	50	680	51
52	MOTOR	1998	1,544	40	20	77	37	1,473	52
53	SPRINKLER SYSTEM	1998	3,500	90	20	175	85	4,318	53
54	FAUCETS, COUPLINGS	1998	10,159	260	20	508	248	5,783	54
55	COMPRESSORS	1998	13,886	356	20	694	338	48,283	55
56	MEDICAL GAS PIPING	1999	124,600	3,195	20	6,230	3,035	79,840	56
57	ELECTRICAL WORK	1999	201,699	5,172	20	10,085	4,913	29,271	57
58	CHILLER REPLACEMENT	1999	76,355	1,958	20	3,818	1,860	248	58
59	AIR CARRIER	1999	693	18	20	35	17	3,895	59
60	CARPETING	1999	4,921	126	20	492	366	49,282	60
61	LOADING RAMP & PATIO	1999	127,175	3,261	20	6,359	3,098	1,049	61
62	SPRINKLER REPAIRS	1999	2,850	73	20	143	70	2,938	62
63	HEATING AND COOLING	1999	8,208	210	20	410	200	675	63
64	FLOW DEVICE OXYGEN	1999	1,760	45	20	88	43	4,544	64
65	ER GENER DESIGN	1999	11,614	298	20	568	270	267	65
66	DOOR CENSORS	1999	718	18	20	36	18	6,992	66
67	SIGNS	1999	18,235	468	20	912	444	329	67
68	METAL INCLOSURE	1999	934	24	20	47	23	24,887	68
69	PARKING AND AISLE PAVE	1999	65,443	1,678	20	3,272	1,594		69
70	TOTAL (lines 4 thru 69)		\$ 6,055,069	\$ 173,540		\$ 194,450	\$ 20,910	\$ 2,736,725	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:

01/01/2006 Ending: 12/31/2006

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	\$ 173,540		\$ 194,450	\$ 20,910	\$ 2,736,725	1
2	NURSE CALL SYSTEM	1999	49,222	1,262	20	2,461	1,199	18,663	2
3	LOAD RAMP DESIGN	1999	14,368	368	20	718	350	5,565	3
4	DOOR LOCKS	1999	2,781	71	20	139	68	1,019	4
5	FIRE PANEL	1999	978	25	20	49	24	372	5
6	NURSE CALL SYSTEM	2000	49,221	1,262	20	2,461	1,199	16,817	6
7	KEYLESS ENTRY SYSTEM	2000	1,250	32	20	62	30	426	7
8	ELECTRICAL OUTLETS	2000	7,600	195	20	380	185	2,406	8
9	VENTILATION BOILER	2000	5,696	146	20	284	138	1,752	9
10	WEIL MCLAIN BOILER	2000	50,425	1,293	20	2,521	1,228	13,025	10
11	HOT WATER BOILER	2000	9,172	235	20	459	224	2,601	11
12									12
13	TELEPHONE SYSTEM	1999	83,381	2,138	20	4,169	2,031	59,756	13
14	TELEPHONE SYSTEM ENHANCEMENT	2000	1,716	44	10	172	128	1,204	14
15									15
16	PICK MGMT GROUP	1996	48,986	1,256	20	(910)	(2,166)	48,986	16
17									17
18	DIALYSIS SPACE/MEDICAL & GAS UPGRADES	2001	33,596	1,222	27.5	1,221	(1)	6,750	18
19	COOLING COIL REPLACEMENT	2001	24,604	894	27.5	895	1	4,960	19
20									20
21	BOILER	2002	49,501	1,800	20	2,475	675	11,138	21
22	VALVES/BOOSTER PUMP	2002	2,430	88	20	122	34	549	22
23	DIALYSIS ROOM	2002	89,870	3,268	20	4,494	1,226	20,223	23
24	REMOVE & REPAPER	2002	10,972	399	20	549	150	2,470	24
25	FLOORING/DRAPERIES	2002	27,204	2,194	20	1,360	(834)	7,348	25
26									26
27	ELEV CAB REPLACEMENT	2003	6,850	249	27.5	249		861	27
28	REPAIR FLUE / REMOVE & REPLACE GREASE TRAP	2003	12,463	453	27.5	453		1,567	28
29	BLINDS	2003	1,760	64	27.5	64		221	29
30	REPAIR AIR HANDLER/REPLACE DIGITAL THERMOSTAT	2003	5,690	207	27.5	207		716	30
31	DOORS	2003	1,387	51	27.5	51		176	31
32	SIDEWALK REPAIRS	2003	800	29	27.5	29		101	32
33	HOT WATER BOILER	2003	29,001	1,055	27.5	1,055		4,000	33
34	TOTAL (lines 1 thru 33)		\$ 6,675,993	\$ 193,840		\$ 220,639	\$ 26,799	\$ 2,970,397	34

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

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 12B, Carried Forward		\$ 6,675,993	\$ 193,840		\$ 220,639	\$ 26,799	\$ 2,970,397	1
2	CARPET	2004	5,459	1,114	5	1,092	(22)	3,003	2
3	SEWER LINE REPLACEMENT	2004	2,385	87	27.5	87		214	3
4	FIRE SUPPRESSION SYSTEM	2004	2,579	94	27.5	94		231	4
5	ELEVATOR CAB REPLACEMENT	2004	6,850	249	27.5	249		612	5
6	REPLACE SEWER LINE	2004	20,625	750	27.5	750		750	6
7	CARPETING	2005	57,619	2,095	27.5	2,095		3,055	7
8	PLUMBING	2005	1,636	59	27.5	59		86	8
9	WINDOW TREATMENT	2005	1,783	65	27.5	65		95	9
10	OXYGEN SYSTEM/DINING ROOM REMODEL	2005	610,957	22,217	27.5	22,217		32,400	10
11	CARPETING	2006	2,063	34	27.5	34		34	11
12	WALLCOVERING	2006	40,424	674	27.5	674		674	12
13	INTERIOR DESIGN-CORRIDORS/DINING ROOM	2006	6,716	112	27.5	112		112	13
14	INSTALL 2 TANK UNITS	2006	18,520	308	27.5	308		308	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	TOTAL (lines 1 thru 33)		\$ 7,453,609	\$ 221,698		\$ 248,475	\$ 26,777	\$ 3,011,971	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:

01/01/2006

Ending:

12/31/2006

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	\$ 1,015,919	\$ 163,521	\$ 103,109	\$ (60,412)	10 YRS	\$ 527,330	71
72	Current Year Purchases	87,821	17,564	4,391	(13,173)	10 YRS	4,391	72
73	Fully Depreciated Assets	142,562			0		142,562	73
74	RELATED PARTY	2,553,881	41,310		(41,310)			74
75	TOTALS	\$ 3,800,183	\$ 222,395	\$ 107,500	\$ (114,895)		\$ 674,283	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				\$	\$	\$	0		\$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 0	\$ 0	\$ 0	\$ 0		\$ 0	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)	\$ 11,253,792	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 444,093	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 355,975	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (88,118)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,686,254	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NA

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

If NO, see instructions. YES NO

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

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

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

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

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: \$ 39,625 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. _____/2007 \$ _____

13. _____/2008 \$ _____

14. _____/2009 \$ _____

* 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 CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs 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>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 CNA _____</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 CNA _____</p>
<p>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>		

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		Contract	Total
		1 Drop-outs	2 Completed		
1	Community College Tuition	\$	\$	\$	\$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	TOTALS	\$ 0	\$ 0	\$ 0	\$ 0
10	SUM OF line 9, col. 1 and 2 (e)	\$ 0			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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	39-3	hrs	\$		\$ 5,487	\$		\$ 5,487	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			28,415			28,415	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			64			64	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs			205,240			205,240	8
9	Pharmacy	39-2	# of prescripts				982,188		982,188	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	SUPPLIES,LAB,RANTALS,O2 Other (specify):						572,177		572,177	13
14	TOTAL			\$		\$ 239,206	\$ 1,554,365		\$ 1,793,571	14

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

Facility Name & ID Number BALLARD NURSING CENTER

0023093

Report Period Beginning: 01/01/2006

Ending:

12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(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>208,400</u>)	8,318,623		3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	410,872		6
7	Other Prepaid Expenses	216,221		7
8	Accounts Receivable (owners or related parties)	990,879		8
9	Other(specify): _____			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 9,936,595	\$ 0	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	1,485,639		15
16	Equipment, at Historical Cost	2,404,781		16
17	Accumulated Depreciation (book methods)	(1,742,854)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): _____			22
23	Other(specify): <u>LEASE DEPOSIT</u>	12,973		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,160,539	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 12,097,134	\$ 0	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 4,053,413	\$	26
27	Officer's Accounts Payable	972,000		27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	3,097,781		29
30	Accrued Salaries Payable	869,335		30
31	Accrued Taxes Payable (excluding real estate taxes)	203,924		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	24,289		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)	\$ 9,220,742	\$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,261,972		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)	\$ 2,261,972	\$ 0	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 11,482,714	\$ 0	46
47	TOTAL EQUITY (page 18, line 24)	\$ 614,420	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 12,097,134	\$ 0	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 359,586	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 359,586	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	254,834	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)	\$ 254,834	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 614,420	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	\$ 13,819,396	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 13,819,396	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,387,283	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,387,283	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	17,045	13
14	Non-Patient Meals	12,879	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 29,924	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	6,115	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6,115	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28		3,492	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,492	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 15,246,210	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,575,480	31
32	Health Care	6,366,692	32
33	General Administration	3,456,565	33
	B. Capital Expense		
34	Ownership	1,670,536	34
	C. Ancillary Expense		
35	Special Cost Centers	1,793,571	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)*	\$ 14,989,317	40
41	Income before Income Taxes (line 30 minus line 40)**	256,893	41
42	Income Taxes	(2,059)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 254,834	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: **01/01/2006**

Ending: **12/31/2006**

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
2	Assistant Director of Nursing	7,172	6,963	243,721	35.00
3	Registered Nurses	51,005	49,520	1,568,231	31.67
4	Licensed Practical Nurses	15,187	11,250	290,236	25.80
5	CNAs & Orderlies	139,277	134,568	1,609,187	11.96
6	CNA Trainees				6
7	Licensed Therapist	85,657	63,450	1,775,426	27.98
8	Rehab/Therapy Aides	6,285	6,815	100,762	14.79
9	Activity Director				9
10	Activity Assistants	10,741	11,937	141,832	11.88
11	Social Service Workers	5,482	6,069	119,500	19.69
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook				14
15	Cook Helpers/Assistants	9,609	12,482	349,809	28.03
16	Dishwashers				16
17	Maintenance Workers	4,870	5,116	60,218	11.77
18	Housekeepers	8,522	11,116	298,764	26.88
19	Laundry	7,469	8,371	87,720	10.48
20	Administrator	6,448	7,216	291,650	40.42
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	23,993	25,993	648,161	24.94
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	1,994	2,124	31,478	14.82
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	383,711	362,990	\$ 7,616,695 *	\$ 20.98

* 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	M	\$ 14,480	1-3
36	Medical Director	O	104,300	9-3
37	Medical Records Consultant	N	4,224	10-3
38	Nurse Consultant	T	0	10-3
39	Pharmacist Consultant	H	5,700	10-3
40	Physical Therapy Consultant	L	0	10a-3
41	Occupational Therapy Consultant	Y	30,000	10a-3
42	Respiratory Therapy Consultant		0	10a-3
43	Speech Therapy Consultant	F	0	10a-3
44	Activity Consultant	E	1,280	11-3
45	Social Service Consultant	E	3,426	12-3
46	Other(specify)	S		
47				
48				
49	TOTAL (lines 35 - 48)		\$ 163,410	

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$	10-3
51	Licensed Practical Nurses		107,356	10-3
52	Certified Nurse Assistants/Aides			10-3
53	TOTAL (lines 50 - 52)		\$ 107,356	

Facility Name & ID Number **BALLARD NURSING CENTER**# **0023093**Report Period Beginning: **01/01/2006**Ending: **12/31/2006****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. ICLTC \$ 13,860
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 7,680 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 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, 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. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ 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