

		FOR BHF USE					

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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.

I. IDPH Facility ID Number: 8049116

Facility Name: Harvard Memorial Hospital

Address: 901 South Grant, P.O. Box 850 Harvard 60033
 Number City Zip Code

County: McHenry

Telephone Number: (608)755-5362 **Fax #** (608)741-7368

HFS ID Number: 311551871-002

Date of Initial License for Current Owners: 1954

Type of Ownership:

<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input checked="" 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 <u>501C(3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Julie Goodman **Telephone Number:** (608)755-5362 x5008

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/2005 to 6/30/2006 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Kathy Kus</u>	
	(Title) <u>Administrator</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) (____) _____ Fax # (____) _____	

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

Facility Name & ID Number Harvard Memorial Hospital# 8049116 Report Period Beginning: 7/1/2005 Ending: 6/30/2006

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 45

	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	<u>45</u>	Skilled (SNF)	<u>45</u>	<u>16,425</u>	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	<u>45</u>	TOTALS	<u>45</u>	<u>16,425</u>	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	<u>84</u>	<u>9,040</u>	<u>512</u>	<u>9,636</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>84</u>	<u>9,040</u>	<u>512</u>	<u>9,636</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 58.67%

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)

Meals on Wheels, Employee MealsF. 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 1976

J. Was the facility purchased or leased after January 1, 1978?

YES Date March 2003 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 14 and days of care provided 512

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 6/30/2006 Fiscal Year: 6/30/2006

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

Facility Name & ID Number Harvard Memorial Hospital # 8049116 Report Period Beginning: 7/1/2005 Ending: 6/30/2006

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	333,228	25,300	115,669	474,197	(4,655)	469,542	(55,240)	414,302			1
2	Food Purchase											2
3	Housekeeping	221,219	21,577	24,041	266,837		266,837	(218,094)	48,743			3
4	Laundry	14,924	2,257	89,549	106,730		106,730	(45,966)	60,764			4
5	Heat and Other Utilities					317,900	317,900	(259,830)	58,070			5
6	Maintenance		697	773,625	774,322	(363,493)	410,829	(335,784)	75,045			6
7	Other (specify):* Central Supply	52,299	(109)	(272)	51,918	(975)	50,943	(5,993)	44,950			7
8	TOTAL General Services	621,670	49,722	1,002,612	1,674,004	(51,223)	1,622,781	(920,907)	701,874			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	4,285,741	1,611,109	2,056,902	7,953,752	(5,415,345)	2,538,407	(133,907)	2,404,500			10
10a	Therapy	481,428	18,919	(10,116)	490,231	(11,693)	478,538	(56,299)	422,239			10a
11	Activities											11
12	Social Services											12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*	1,162,408	256,567	815,918	2,234,893	(2,234,893)						15
16	TOTAL Health Care and Programs	5,929,577	1,886,595	2,862,704	10,678,876	(7,661,931)	3,016,945	(190,206)	2,826,739			16
	C. General Administration											
17	Administrative	43,622	2,577	99,675	145,874	(44,644)	101,230	(47,320)	53,910			17
18	Directors Fees											18
19	Professional Services					11,133	11,133	(5,204)	5,929			19
20	Dues, Fees, Subscriptions & Promotions					53,887	53,887	(25,189)	28,698			20
21	Clerical & General Office Expenses	310,765	8,664	452,502	771,931	(2,293)	769,638	(359,767)	409,871			21
22	Employee Benefits & Payroll Taxes			2,119,713	2,119,713	(261,970)	1,857,743	(1,544,960)	312,783			22
23	Inservice Training & Education											23
24	Travel and Seminar					38,526	38,526	(18,009)	20,517			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			2,671	2,671		2,671	(1,249)	1,422			26
27	Other (specify):* HR & Marketing	47	1,540	643,063	644,650	(17,863)	626,787	(521,257)	105,530			27
28	TOTAL General Administration	354,434	12,781	3,317,624	3,684,839	(223,224)	3,461,615	(2,522,955)	938,660			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,905,681	1,949,098	7,182,940	16,037,719	(7,936,378)	8,101,341	(3,634,068)	4,467,273			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Harvard Memorial Hospital

#8049116

Report Period Beginning:

7/1/2005

Ending:

6/30/2006

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			1,200,075	1,200,075		1,200,075	(1,189,763)	10,312			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			847,097	847,097		847,097	(847,097)				32
33	Real Estate Taxes					42,596	42,596	(42,596)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles					20,412	20,412	(13,696)	6,716			35
36	Other (specify):* Bad Debt			1,494,634	1,494,634		1,494,634	(1,494,634)				36
37	TOTAL Ownership			3,541,806	3,541,806	63,008	3,604,814	(3,587,786)	17,028			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					143	143		143			38
39	Ancillary Service Centers					7,848,589	7,848,589	(7,848,589)				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					24,638	24,638		24,638			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers					7,873,370	7,873,370	(7,848,589)	24,781			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,905,681	1,949,098	10,724,746	19,579,525		19,579,525	(15,070,443)	4,509,082			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 Harvard Memorial Hospital

8049116

Report Period Beginning: 7/1/2005

Ending: 6/30/2006

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				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				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$		\$	30

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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$		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		see schedule		42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule	X		see schedule		45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY					
48		49		50	
				51	
					52

Harvard Memorial Hospital

ID# 8049116

Report Period Beginning: 7/1/2005

Ending: 6/30/2006

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1	Dietary Expense not related to SNF care	\$ (55,240)	1
2	Housekeeping Expenses not related to SNF care	(218,094)	2
3	Laundry Expenses not related to SNF care	(45,966)	3
4	Heat and Other Utilities not related to SNF care	(259,830)	4
5	Maintenance Expenses not related to SNF care	(335,784)	5
6	Central Supply Expense not related to SNF care	(5,993)	6
7	Nursing & Medical Records Expenses not related to SNF	(133,907)	7
8	Therapy Expenses not related to SNF care	(56,299)	8
9	Administrative Expenses not related to SNF care	(47,320)	9
10	Professional Services not related to SNF care	(5,204)	10
11	Dues, Fees & Subscriptions not related to SNF care	(25,189)	11
12	Clerical & General Office Expense not related to SNF	(359,767)	12
13	Employee Benefits & Payroll Taxes not related to SNF	(1,544,960)	13
14	Travel & Seminar Expense not related to SNF care	(18,009)	14
15	Insurance Expenses not related to SNF care	(1,249)	15
16	Human Resources & Marketing Expense not related to SN	(521,257)	16
17	Depreciation Expense not related to SNF care	(1,189,763)	17
18	Interest Expense not related to SNF care	(847,097)	18
19	Real Estate Taxes not related to SNF care	(42,596)	19
20	Rent Expense-Equipment not related to SNF care	(13,696)	20
21	Ancillary Services related to Acute not SNF Operations	(7,848,589)	21
22	Bad Debt Expense	(1,494,634)	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	(15,070,443)	49

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
Mercy Health System	100			Mercy Hospital	Janesville, WI	Hospital
				Mercy Assisted Care	Janesville, WI	Includes Homecare
				Mercy Alliance	Janesville, WI	Parent Corporation

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V			N/A				2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

Facility Name & ID Number Harvard Memorial Hospital # 8049116 Report Period Beginning: 7/1/2005 Ending: 6/30/2006

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									\$		1
2	N/A										2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		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 Harvard Memorial Hospital

8049116

Report Period Beginning: 7/1/2005

Ending: 7/30/2006

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

Name of Related Organization Mercy Health System
 Street Address 1000 Mineral Point Ave
 City / State / Zip Code Janesville, WI 53547
 Phone Number (608)755-5362 ext 5008
 Fax Number (608)741-7368

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

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	6	Maintenance	hrs worked	48,407	3	\$ 1,066,752	\$ 9,943	\$ 219,115	1
2	27	Marketing	hrs worked	43,252	5	833,488	2,935	56,559	2
3	21	Information Systems	hrs worked	77,021	4	2,068,682	2,435	65,401	3
4	21	Finance	hrs worked	45,367	6	1,151,579	5,857	148,672	4
5	27	Human Resources	hrs worked	42,663	3	995,113	5,315	123,972	5
6	21	Business Office	hrs worked	240,610	2	3,350,755	6,721	93,597	6
7	17	Executive Salaries	hrs worked	42,407	4	4,806,989	1,059	120,042	7
8	22	Pension Expense	actual expense	1	1	299,400	0	299,400	8
9	22	Workers Compensation	FTEs	2,757	5	1,295,000	139	65,290	9
10	26	Gen/Prof Liability Insurance	actual expense	1	1	51,600	0	51,600	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					\$ 15,919,358	\$ 14,273,358	\$ 1,243,648	25

Facility Name & ID Number

Harvard Memorial Hospital

8049116

Report Period Beginning:

7/1/2005

Ending:

6/30/2006

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 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	1998 Bond Issue	X		Medical Clinic Construction	\$75,000 Annual	1998	\$ 1,750,000	\$ 1,275,000	2016	Variable	\$ 12,204	1
2	Mercy Alliance Loans	X		Hospital Renovations	Varies	2003	5,570,000	12,710,545	2018	6.1360	600,000	2
3	Capital Leases	X		Hospital Equipment	Various	Various	872,000	6,622	Various	Various	6,891	3
4	Interentity Bonds Payable 2005	X		Intercompany LT Payable	Various	2005	3,901,107	5,072,713	None	4.7500	228,000	4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$ 12,093,107	\$ 19,064,881			\$ 847,095	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 12,093,107	\$ 19,064,881			\$ 847,095	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ not broken out Line # 26* 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.)

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 Harvard Memorial Hospital COUNTY McHenry

FACILITY IDPH LICENSE NUMBER 8049116

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE (____) _____ FAX #: (____) _____

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. _____	_____	\$ _____	\$ _____
2. <u>N/A Property Tax Exempt</u>	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

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 _____ 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 Harvard Memorial Hospital

8049116 Report Period Beginning:

7/1/2005 Ending:

6/30/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 81,662 B. General Construction Type: Exterior Brick Frame Block Number of Stories 2

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).

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	Hospital/SNF	85,800	1956	\$ 3,452	1
2					2
3	TOTALS	85,800		\$ 3,452	3

Facility Name & ID Number **Harvard Memorial Hospital**

8049116

Report Period Beginning:

7/1/2005

Ending:

6/30/2006

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
Improvement Type**											
9		Metal Lockers		1976	771		20			771	9
10		Door Alarm System		1989	1,055		10			1,055	10
11		Wiring for Care Center Phones		1990	418		10			418	11
12		Acitivites Office		1996	19,981	1,332	15	1,332		12,765	12
13		A/C Compressor		1996	1,922	128	15	128		1,315	13
14		Cabinets		1996	11,214	561	20	561		5,658	14
15		Wanderguard Unit		1999	2,652	265	10	265		1,833	15
16		Construct Firewall		2003	3,761	251	15	251		627	16
17		Skiled Care Nursing Station		2004	9,522	635	15	635		1,587	17
18		Top Upper Cabinets		2005	1,979	198	10	198		297	18
19		Care Center Wiring		2005	305	44	7	44		65	19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number **Harvard Memorial Hospital**

8049116

Report Period Beginning:

7/1/2005

Ending:

6/30/2006

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

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

Facility Name & ID Number Harvard Memorial Hospital # 8049116 Report Period Beginning: 7/1/2005 Ending: 6/30/2006

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	\$ 48,102	\$ 6,114	\$ 6,114	\$		\$ 34,658	71
72	Current Year Purchases	11,135	785	785			785	72
73	Fully Depreciated Assets	118,042					118,042	73
74								74
75	TOTALS	\$ 177,279	\$ 6,899	\$ 6,899	\$		\$ 153,485	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)	\$ 234,311	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 10,312	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 10,312	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 179,877	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	Building	\$ 14,606,712	\$ 685,629	\$ 6,456,007	86
87	Equipment	6,646,072	470,194	3,919,028	87
88	Land Improvements	675,837	33,939	336,154	88
89					89
90					90
91	TOTALS	\$ 21,928,621	\$ 1,189,763	\$ 10,711,189	91

G. Construction-in-Progress

	Description	Cost	
92	Surg/Pt Room Remodel	\$ 37,519	92
93	Cafeteria Remodel	45,457	93
94	MHH Facility Planning	1,845	94
95		\$ 84,820	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: All rental equipment is short-term rental

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

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	\$ _____

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: \$ 6,716 Description: Short term rental of copier machine, O2 concentrators and C-pap machines

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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 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>
---	---	--

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	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5 Units Cost					
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

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

Facility Name & ID Number Harvard Memorial Hospital# 8049116Report Period Beginning: 7/1/2005

Ending:

6/30/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2006

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 668,919	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>3,472,791</u>)	3,716,971		3
4	Supply Inventory (priced at)	609,150		4
5	Short-Term Investments	80,518		5
6	Prepaid Insurance	107,301		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,182,859	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	898,441		13
14	Buildings, at Historical Cost	14,660,291		14
15	Leasehold Improvements, at Historical Cost	84,820		15
16	Equipment, at Historical Cost	6,823,352		16
17	Accumulated Depreciation (book methods)	(10,891,066)		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>Debt Issuance Costs</u>	137,060		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 11,712,898	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 16,895,757	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 194,131	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	453,796		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	21,294		32
33	Accrued Interest Payable	1,443,741		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Other Current Liabilities</u>	907,022		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,019,984	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	19,064,880		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)	\$ 19,064,880	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 22,084,864	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (5,189,107)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 16,895,757	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (5,606,355)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (5,606,355)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	388,559	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) <u>Transfer of Assets with Mercy</u>	28,689	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 417,248	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)	\$ (5,189,107)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Harvard Memorial Hospital# 8049116Report Period Beginning: 7/1/2005Ending: 6/30/2006**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	\$ 34,260,959	1
2	Discounts and Allowances for all Levels	(14,520,713)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 19,740,246	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	53,304	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	46,675	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 99,979	23
D. Non-Operating Revenue			
24	Contributions	100,000	24
25	Interest and Other Investment Income***	6,798	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 106,798	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Non-Operating Income	21,061	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 21,061	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 19,968,084	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,673,863	31
32	Health Care	10,654,381	32
33	General Administration	5,179,473	33
B. Capital Expense			
34	Ownership	2,047,170	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	24,638	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 19,579,525	40
41	Income before Income Taxes (line 30 minus line 40)**	388,559	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 388,559	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 Harvard Memorial Hospital

8049116

Report Period Beginning: 7/1/2005

Ending:

6/30/2006

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	8,144	9,072	\$ 369,576	\$ 40.74	1
2	Assistant Director of Nursing					2
3	Registered Nurses	90,093	98,467	2,798,230	28.42	3
4	Licensed Practical Nurses	916	929	17,799	19.16	4
5	CNAs & Orderlies	49,776	53,514	600,806	11.23	5
6	CNA Trainees					6
7	Licensed Therapist	6,012	6,445	184,202	28.58	7
8	Rehab/Therapy Aides	13,693	14,934	159,377	10.67	8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	8,445	9,377	131,391	14.01	13
14	Head Cook					14
15	Cook Helpers/Assistants	19,768	21,242	201,836	9.50	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	20,458	22,531	221,219	9.82	18
19	Laundry	1,716	1,881	14,924	7.93	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	12,544	13,834	204,207	14.76	22
23	Office Manager					23
24	Clerical	28,285	31,072	399,261	12.85	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	18,038	19,640	264,926	13.49	31
32	Other Health Care(specify)	57,082	61,518	1,337,927	21.75	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	334,970	364,456	\$ 6,905,681 *	\$ 18.95	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	\$		35
36	Medical Director			36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant			39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,053	\$ 62,901	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	2,305	56,534	10-3	52
53	TOTAL (lines 50 - 52)	3,358	\$ 119,435		53

Facility Name & ID Number Harvard Memorial Hospital

8049116

Report Period Beginning: 7/1/2005

Ending: 6/30/2006

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		
clerical staff	clerk	0	\$ 43,622	Workers' Compensation Insurance	\$ 74,607	IDPH License Fee	\$		
				Unemployment Compensation Insurance	17,295	Advertising: Employee Recruitment			
				FICA Taxes	274,949	Health Care Worker Background Check			
				Employee Health Insurance	1,058,489	(Indicate # of checks performed)			
				Employee Meals	0	Professional Membership & Dues	34,638		
				Illinois Municipal Retirement Fund (IMRF)*	0	Publications/Subscriptions	4,037		
				Pension	299,574	Misc. Promotional Functions	15,212		
				Employer TDA Match	71,086	Allocated to NON SNF areas	(25,189)		
				Life & Disability Insurance	30,912				
				Employee Health	4,239	Less: Public Relations Expense	()		
				Accrued Paid Leave	19,635	Non-allowable advertising	()		
				Other	6,957	Yellow page advertising	()		
				Allocated to NON SNF areas	(1,544,960)				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)		
\$ 43,622				\$ 312,783			\$ 28,698		
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	
Dues & Membership			\$ 30,578	N/A - none		\$	Out-of-State Travel	\$	
Audit & Legal Fees			11,132						
Admin salaries from parent			120,000						
Other allocations			(62,035)				In-State Travel	18,499	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			Seminar Expense		20,027
\$ 99,675				\$			Allocated to NON SNF areas		(18,009)
C. Professional Services									
Vendor/Payee	Type		Amount						
WIPFLI	audit fees		\$ 7,800				Entertainment Expense		()
WIPFLI	cost rpt prep		1,550				(agree to Sch. V, line 24, col. 8)		
Virchow Krause	tax returns		1,500				TOTAL		\$ 20,517
Franks, Gerkin & McKenn	legal fees		283						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				TOTAL					
\$ 11,133				\$					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Harvard Memorial Hospital

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? no
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? no If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ not available Line _____
- (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. \$ 24,638
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. \$ none Has any meal income been offset against related costs? yes Indicate the amount. \$ 53,304
- (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? N/A
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? no**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: WIPFLI The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? yes 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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.