



Facility Name & ID Number BALLARD NURSING CENTER

# 0023093 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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			19,939	19,939	8
9	SNF/PED					9
10	ICF	21,066	5,322		26,388	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,066	5,322	19,939	46,327	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 54.95%

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 13,815

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number **BALLARD NURSING CENTER** # **0023093** Report Period Beginning: **01/01/2007** Ending: **12/31/2007**

**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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	400,040	37,050	6,385	443,475		443,475		443,475		1
2	Food Purchase		251,388		251,388		251,388	(13,856)	237,532		2
3	Housekeeping	352,017	72,862		424,879		424,879		424,879		3
4	Laundry	79,531	45,262		124,793		124,793		124,793		4
5	Heat and Other Utilities			296,770	296,770		296,770		296,770		5
6	Maintenance	87,787	129,530	37,901	255,218		255,218		255,218		6
7	Other (specify):*			30,498	30,498		30,498		30,498		7
8	<b>TOTAL General Services</b>	<b>919,375</b>	<b>536,092</b>	<b>371,554</b>	<b>1,827,021</b>		<b>1,827,021</b>	<b>(13,856)</b>	<b>1,813,165</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			116,800	116,800		116,800		116,800		9
10	Nursing and Medical Records	4,133,923	210,135	16,682	4,360,740	31,424	4,392,164		4,392,164		10
10a	Therapy	1,960,200		30,000	1,990,200		1,990,200		1,990,200		10a
11	Activities	169,639	18,479	1,172	189,290		189,290	(68,154)	121,136		11
12	Social Services	122,706			122,706		122,706		122,706		12
13	CNA Training										13
14	Program Transportation			1,031	1,031		1,031		1,031		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>6,386,468</b>	<b>228,614</b>	<b>165,685</b>	<b>6,780,767</b>	<b>31,424</b>	<b>6,812,191</b>	<b>(68,154)</b>	<b>6,744,037</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	230,270		306,700	536,970		536,970	(6,690)	530,280		17
18	Directors Fees										18
19	Professional Services			166,568	166,568	(31,424)	135,144	18,187	153,331		19
20	Dues, Fees, Subscriptions & Promotions			153,475	153,475		153,475	(112,737)	40,738		20
21	Clerical & General Office Expenses	633,330	81,275	115,513	830,118		830,118	(241,803)	588,315		21
22	Employee Benefits & Payroll Taxes			1,337,674	1,337,674		1,337,674	(1,716)	1,335,958		22
23	Inservice Training & Education			18,251	18,251		18,251		18,251		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			32,840	32,840		32,840		32,840		25
26	Insurance-Prop.Liab.Malpractice			208,124	208,124		208,124		208,124		26
27	Other (specify):*							16,783	16,783		27
28	<b>TOTAL General Administration</b>	<b>863,600</b>	<b>81,275</b>	<b>2,339,145</b>	<b>3,284,020</b>	<b>(31,424)</b>	<b>3,252,596</b>	<b>(327,976)</b>	<b>2,924,620</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>8,169,443</b>	<b>845,981</b>	<b>2,876,384</b>	<b>11,891,808</b>		<b>11,891,808</b>	<b>(409,986)</b>	<b>11,481,822</b>		<b>29</b>

\*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
<b>1</b>	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	6,385
	REPAIRS & MAINTENANCE	0
		0
		6,385
<b>3</b>	<b>HOUSEKEEPING</b>	
		0
		0
		0
<b>4</b>	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
<b>5</b>	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	104,212
	ELECTRICITY	116,222
	WATER	65,425
	CABLE TV - LOBBY	10,911
		0
		296,770
<b>6</b>	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	20,575
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	0
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	5,817
	FIRE SERVICE	0
	CONTRACTED BUILDING MAINTENANCE	11,509
		0
		0
		0
		37,901
<b>7</b>	<b>OTHER</b>	
	SCAVENGER	30,498
	SECURITY SERVICE	0
		0
		0
		30,498
<b>9</b>	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	116,800
		116,800

LINE	SCHED REF	TOTAL
<b>10</b>	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	6,758
	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
		16,682
<b>10a</b>	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	0
	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
<b>11</b>	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	1,172
		0
		1,172
<b>12</b>	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	0
		0
		0
<b>13</b>	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
<b>14</b>	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	1,031
<b>17</b>	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	306,700
	<b>DIRECTORS FEES</b>	
<b>18</b>	DIRECTORS FEES	0
<b>19</b>	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	44,460
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	122,108
		0
		166,568
<b>20</b>	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	4,561
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	98,714
	EMPLOYEE WANT ADS XIX F	7,429
	CONTRIBUTIONS VI 20 XIX F	6,946
	DUES & SUBSCRIPTIONS XIX F	23,566
	LICENSES & PERMITS XIX F	8,203
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	1,377
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	1,139
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,540
	PATIENT BACKGROUND CHECKS XIX F	0
		153,475
<b>21</b>	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	12,598
	PENALTIES / OVERDRAFT CHARGES VI 18	28,611
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	74,304
	MESSENGER SERVICE	0
		0
		115,513

LINE	SCHED REF	TOTAL
<b>22</b>	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	582,395
	UNEMPLOYMENT COMPENSATION XIX D	55,301
	WORKERS COMPENSATION INSURANC XIX D	106,425
	HOSPITALIZATION INSURANCE XIX D	579,228
	EMPLOYEE BENEFITS - OTHER XIX D	12,609
	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
		1,337,674
<b>23</b>	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	18,251
		18,251
<b>24</b>	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
<b>25</b>	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	32,840
		32,840
<b>26</b>	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	208,124
		208,124
<b>27</b>	<b>OTHER</b>	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

2,876,384

**BALLARD NURSING CENTER  
SCHEDULES  
12/31/2007**

**EMPLOYEE MEAL RECLASSIFICATION  
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22**

TOTAL FOOD PURCHASE	251,388
LESS SALES TAX	<u>(641)</u>
NET FOOD	250,747

TOTAL PATIENT CENSUS	46,327
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	138,981

ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	138,981
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	138,981

NET FOOD	250,747
DIVIDE TOTAL MEALS/YEAR	<u>138,981</u>

COST PER MEAL	1.80
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	<b>0</b>

=====

Facility Name &amp; ID Number

BALLARD NURSING CENTER

#0023093

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			210,989	210,989		210,989	167,885	378,874			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			216,821	216,821		216,821	547,267	764,088			32
33	Real Estate Taxes							361,520	361,520			33
34	Rent-Facility & Grounds			1,122,700	1,122,700		1,122,700	(1,122,700)				34
35	Rent-Equipment & Vehicles			39,193	39,193		39,193		39,193			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,589,703	1,589,703		1,589,703	(46,028)	1,543,675			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,151,286	532,641	1,683,927		1,683,927		1,683,927			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			126,473	126,473		126,473		126,473			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		1,151,286	659,114	1,810,400		1,810,400		1,810,400			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	8,169,443	1,997,267	5,125,201	15,291,911		15,291,911	(456,014)	14,835,897			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:

**01/01/2007**

Ending:

**12/31/2007**

**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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(13,215)	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	(47,597)	30		9
10	Interest and Other Investment Income	(8,297)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(641)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(28,611)	21		18
19	Entertainment	(4,561)	20		19
20	Contributions	(8,085)	20		20
21	Owner or Key-Man Insurance	(1,716)	22		21
22	Special Legal Fees & Legal Retainers	5,483	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(98,714)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,377)	20		28
29	Other-Attach Schedule	(281,346)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (488,677)		\$	30

<b>BHF USE ONLY</b>					
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	
		<b>Amount</b>	<b>Reference</b>	
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)	32,663		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 32,663		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (456,014)		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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BALLARD NURSING CENTER

ID# 0023093

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	MARKETING SALARY	\$ (213,192)	21	1
2	CRUISE GRANT	(50,000)	11	2
3	BARBER & BEAUTY INCOME	(18,154)	11	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	<b>Total</b>	(281,346)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number BALLARD NURSING CENTER# 0023093

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## 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	(13,856)	0	0	0	0	0	0	0	0	0	0	(13,856)	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	<b>TOTAL General Services</b>	<b>(13,856)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(13,856)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
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	(68,154)	0	0	0	0	0	0	0	0	0	0	(68,154)	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	<b>TOTAL Health Care and Programs</b>	<b>(68,154)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(68,154)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(6,690)	0	0	0	0	0	0	0	0	0	(6,690)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	5,483	12,704	0	0	0	0	0	0	0	0	0	18,187	19
20	Fees, Subscriptions & Promotions	(112,737)	0	0	0	0	0	0	0	0	0	0	(112,737)	20
21	Clerical & General Office Expenses	(241,803)	0	0	0	0	0	0	0	0	0	0	(241,803)	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	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	16,783	0	0	0	0	0	0	0	0	0	16,783	27
28	<b>TOTAL General Administration</b>	<b>(350,773)</b>	<b>22,797</b>	<b>0</b>	<b>(327,976)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(432,783)</b>	<b>22,797</b>	<b>0</b>	<b>(409,986)</b>	<b>29</b>								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BALLARD NURSING CENTER

# 0023093

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(47,597)	215,482	0	0	0	0	0	0	0	0	0	167,885	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,297)	555,564	0	0	0	0	0	0	0	0	0	547,267	32
33	Real Estate Taxes	0	361,520	0	0	0	0	0	0	0	0	0	361,520	33
34	Rent-Facility & Grounds	0	(1,122,700)	0	0	0	0	0	0	0	0	0	(1,122,700)	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	<b>TOTAL Ownership</b>	<b>(55,894)</b>	<b>9,866</b>	<b>0</b>	<b>(46,028)</b>	<b>37</b>								
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(488,677)</b>	<b>32,663</b>	<b>0</b>	<b>(456,014)</b>	<b>45</b>								

**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	NONE		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	\$ 1,122,700	BALLARD PARTNERS	100.00%	\$	\$ (1,122,700)	1
2	V							2
3	V	19 ACCOUNTING FEES		" " "		10,850	10,850	3
4	V	30 DEPRECIATION		" " "		214,226	214,226	4
5	V	32 INTEREST		" " "		555,564	555,564	5
6	V	33 REAL ESTATE TAXES		" " "		361,520	361,520	6
7	V							7
8	V	17 MANAGEMENT FEES	306,700	PICK MANAGEMENT GROUP	100.00%		(306,700)	8
9	V							9
10	V	17 SALARIES		" " "		300,010	300,010	10
11	V	19 DATA PROCESSING		" " "		1,854	1,854	11
12	V	27 PAYROLL TAXES		" " "		16,783	16,783	12
13	V	30 DEPRECIATION		" " "		1,256	1,256	13
14	Total		\$ 1,429,400			\$ 1,462,063	\$ * 32,663	14

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

Facility Name &amp; ID Number

BALLARD NURSING CENTER

#

0023093

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## 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	MOSHE PICK	EXECUTIVE DIR	ADMINISTRATIV	35.00	NONE	40	100.00	SALARY	\$ 150,000	17-7	1
2	ELI PICK	EXECUTIVE DIR	ADMINISTRATIV	32.50	NONE	40	100.00	SALARY	150,000	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 300,000		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

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

# **0023093** Report Period Beginning: **01/01/2007** Ending: **2/31/2007**

**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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number

**BALLARD NURSING CENTER**

# **0023093**

Report Period Beginning:

**01/01/2007**

Ending:

**12/31/2007**

**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		7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Interest Expense	10
		YES	NO				Original	Balance				
<b>A. Directly Facility Related</b>												
<b>Long-Term</b>												
1	M&T REALTY CAPITAL CORP	X		MORTGAGE	\$99,200.00	9/25/06	\$ 9,592,200	\$ 9,505,713	9/25/41	5.8200	\$ 555,564	1
2												2
3												3
4												4
5												5
<b>Working Capital</b>												
6	NEW CENTURY BANK	X		WORKING CAPITAL				2,246,106			194,777	6
7	VARIOUS	X		CAPITAL LEASES				107,087			18,920	7
8				INSURANCE FINANCING							3,124	8
9	<b>TOTAL Facility Related</b>				<b>\$99,200.00</b>		<b>\$ 9,592,200</b>	<b>\$ 11,858,906</b>			<b>\$ 772,385</b>	<b>9</b>
<b>B. Non-Facility Related*</b>												
10												10
11												11
12												12
13												13
14	<b>TOTAL Non-Facility Related</b>						<b>\$</b>	<b>\$</b>			<b>\$</b>	<b>14</b>
15	<b>TOTALS (line 9+line14)</b>						<b>\$ 9,592,200</b>	<b>\$ 11,858,906</b>			<b>\$ 772,385</b>	<b>15</b>

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 2006 report.	\$	<b>361,000</b>	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.)	\$	<b>357,520</b>	2
3. Under or (over) accrual (line 2 minus line 1).	\$	<b>(3,480)</b>	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<b>365,000</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$		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. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	<b>361,520</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	<b>350,873</b>	8
	2003	<b>350,950</b>	9
	2004	<b>353,645</b>	10
	2005	<b>370,004</b>	11
	2006	<b>357,520</b>	12

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

**THE PAYMENT ON LINE 2 APPLIES TO THE 2006 TAX BILL.**

<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2006	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

**2006 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 2006 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 2006.

(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>357,520.00</u>	\$ <u>357,520.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>357,520.00</u>	\$ <u>357,520.00</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

**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:

01/01/2007 Ending:

12/31/2007

**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:**

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

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR 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)	\$ 1,548,837	4
5			1994	995,072	25,515	35	25,515		347,642	5
6			1994	986,459	25,294	35	25,294		331,984	6
7			1995	101,526	2,603	35	2,603		32,646	7
8										8
<b>Improvement Type**</b>										
9	VARIOUS		1980	2,955		20			2,955	9
10	VARIOUS		1981	11,619		20			11,619	10
11	VARIOUS		1982	17,413		20			17,413	11
12	VARIOUS		1984	3,536		20			3,536	12
13	VARIOUS		1985	8,040		20			8,040	13
14	VARIOUS		1986	18,668		20			18,668	14
15	VARIOUS		1987	42,109	722	20		(722)	42,109	15
16	VARIOUS		1988	15,834	350	20		(350)	15,834	16
17	VARIOUS		1990	4,990	158	20	250	92	4,438	17
18	VARIOUS		1991	155,172	2,599	20	7,759	5,160	142,268	18
19	VARIOUS		1992	54,689	1,274	20	2,734	1,460	42,179	19
20	VARIOUS		1993	1,571	50	20	77	27	1,136	20
21	HEATING COOLING SYSTEM		1996	2,312	59	20	116	57	1,344	21
22	INTERIOR SIGNS		1996	350	9	20	18	9	208	22
23	BUILDING IMPROVEMENT		1996	70,114	1,798	20	3,506	1,708	40,611	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 &amp; ID Number BALLARD NURSING CENTER

# 0023093

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

**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)	\$ 1,019	37
38	MAV MOTOR REPLACEMENT	1996	2,000	51	20	100	49	1,158	38
39	INTERIOR SIGNS	1996	663	17	20	33	16	382	39
40	DRAPES	1996	616	16	20	31	15	359	40
41	COMP STATION CABLE	1996	2,566	66	20	128	62	1,483	41
42	HEAT AND COOLING SYSTEM	1997	2,999	77	20	150	73	1,550	42
43	SEWAGE PUMP	1997	2,498	64	20	125	61	1,333	43
44	CAULKING	1998	5,845	150	20	292	142	2,677	44
45	RENOVATION PATIOS	1998	6,134	157	20	307	150	2,917	45
46	A/C REPAIRS	1998	2,124	54	20	106	52	1,016	46
47	PARKING LOT	1998							47
48	ALARM SYSTEM	1998	2,500	64	20	125	61	1,240	48
49	SEWAGE PUMP	1998	2,498	64	20	125	61	1,250	49
50	A/C COUPLINGS	1998	2,905	74	20	145	71	1,402	50
51	PATIO FLOOR	1998	2,040	52	20	102	50	961	51
52	MOTOR	1998	1,544	40	20	77	37	757	52
53	SPRINKLER SYSTEM	1998	3,500	90	20	175	85	1,648	53
54	FAUCETS, COUPLINGS	1998	10,159	260	20	508	248	4,826	54
55	COMPRESSORS	1998	13,886	356	20	694	338	6,477	55
56	MEDICAL GAS PIPING	1999	124,600	3,195	20	6,230	3,035	54,513	56
57	ELECTRICAL WORK	1999	201,699	5,172	20	10,085	4,913	89,925	57
58	CHILLER REPLACEMENT	1999	76,355	1,958	20	3,818	1,860	33,089	58
59	AIR CARRIER	1999	693	18	20	35	17	283	59
60	CARPETING	1999	4,921	126	20	492	366	4,387	60
61	LOADING RAMP & PATIO	1999	127,175	3,261	20	6,359	3,098	55,641	61
62	SPRINKLER REPAIRS	1999	2,850	73	20	143	70	1,192	62
63	HEATING AND COOLING	1999	8,208	210	20	410	200	3,348	63
64	FLOW DEVICE OXYGEN	1999	1,760	45	20	88	43	763	64
65	ER GENER DESIGN	1999	11,614	298	20	568	270	5,112	65
66	DOOR CENSORS	1999	718	18	20	36	18	303	66
67	SIGNS	1999	18,235	468	20	912	444	7,904	67
68	METAL INCLOSURE	1999	934	24	20	47	23	376	68
69	PARKING AND AISLE PAVE	1999	65,443	1,678	20	3,272	1,594	28,159	69
70	TOTAL (lines 4 thru 69)		\$ 6,055,069	\$ 173,136		\$ 194,192	\$ 21,056	\$ 2,930,917	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:

01/01/2007 Ending: 12/31/2007

**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	<b>Totals from Page 12A, Carried Forward</b>		\$ 6,055,069	\$ 173,136		\$ 194,192	\$ 21,056	\$ 2,930,917	1
2	NURSE CALL SYSTEM	1999	49,222	1,262	20	2,461	1,199	21,124	2
3	LOAD RAMP DESIGN	1999	14,368	368	20	718	350	6,283	3
4	DOOR LOCKS	1999	2,781	71	20	139	68	1,158	4
5	FIRE PANEL	1999	978	25	20	49	24	421	5
6	NURSE CALL SYSTEM	2000	49,221	1,262	20	2,461	1,199	19,278	6
7	KEYLESS ENTRY SYSTEM	2000	1,250	32	20	62	30	488	7
8	ELECTRICAL OUTLETS	2000	7,600	195	20	380	185	2,786	8
9	VENTILATION BOILER	2000	5,696	146	20	284	138	2,036	9
10	WEIL MCLAIN BOILER	2000	50,425	1,293	20	2,521	1,228	15,546	10
11	HOT WATER BOILER	2000	9,172	235	20	459	224	3,060	11
12									12
13	TELEPHONE SYSTEM	1999	83,381	2,138	20	4,169	2,031	63,925	13
14	TELEPHONE SYSTEM ENHANCEMENT	2000	1,716	44	10	172	128	1,376	14
15									15
16	PICK MGMT GROUP	1996	48,986	1,256	20		(1,256)	48,986	16
17									17
18	DIALYSIS SPACE/MEDICAL & GAS UPGRADES	2001	33,596	1,222	27.5	1,221	(1)	7,971	18
19	COOLING COIL REPLACEMENT	2001	24,604	894	27.5	895	1	5,855	19
20									20
21	BOILER	2002	49,501	1,800	20	2,475	675	13,613	21
22	VALVES/BOOSTER PUMP	2002	2,430	88	20	122	34	671	22
23	DIALYSIS ROOM	2002	89,870	3,268	20	4,494	1,226	24,717	23
24	REMOVE & REPAPER	2002	10,972	399	20	549	150	3,019	24
25	FLOORING/DRAPERIES	2002	27,204	1,097	20	1,360	263	8,708	25
26									26
27	ELEV CAB REPLACEMENT	2003	6,850	249	27.5	249		1,110	27
28	REPAIR FLUE / REMOVE & REPLACE GREASE TRAP	2003	12,463	453	27.5	453		2,020	28
29	BLINDS	2003	1,760	64	27.5	64		285	29
30	REPAIR AIR HANDLER/REPLACE DIGITAL THERMOSTAT	2003	5,690	207	27.5	207		923	30
31	DOORS	2003	1,387	51	27.5	51		227	31
32	SIDEWALK REPAIRS	2003	800	29	27.5	29		130	32
33	HOT WATER BOILER	2003	29,001	1,055	27.5	1,055		5,055	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,675,993	\$ 192,339		\$ 221,291	\$ 28,952	\$ 3,191,688	34

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

Facility Name &amp; ID Number BALLARD NURSING CENTER

# 0023093

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

## 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	<b>Totals from Page 12B, Carried Forward</b>		\$ 6,675,993	\$ 192,339		\$ 221,291	\$ 28,952	\$ 3,191,688	1
2	CARPET	2004	5,459	668	5	1,092	424	4,095	2
3	SEWER LINE REPLACEMENT	2004	2,385	87	27.5	87		301	3
4	FIRE SUPPRESSION SYSTEM	2004	2,579	94	27.5	94		325	4
5	ELEVATOR CAB REPLACEMENT	2004	6,850	249	27.5	249		861	5
6	REPLACE SEWER LINE	2004	20,625	750	27.5	750		1,500	6
7	CARPETING	2005	57,619	2,095	27.5	2,095		5,150	7
8	PLUMBING	2005	1,636	59	27.5	59		145	8
9	WINDOW TREATMENT	2005	1,783	65	27.5	65		160	9
10	OXYGEN SYSTEM/DINING ROOM REMODEL	2005	610,957	22,217	27.5	22,217		54,617	10
11	CARPETING	2006	2,063	75	27.5	75		109	11
12	WALLCOVERING	2006	40,424	1,470	27.5	1,470		2,144	12
13	INTERIOR DESIGN-CORRIDORS/DINING ROOM	2006	6,716	244	27.5	244		356	13
14	INSTALL 2 TANK UNITS	2006	18,520	673	27.5	673		981	14
15	WINDOW TREATMENT	2007	12,525	1,252	5	1,252		1,252	15
16	CARPETING DINING ROOMS	2007	60,529	6,053	5	6,053		6,053	16
17	PAINT/WALLPAPER/TILE	2007	14,965	1,497	5	1,497		1,497	17
18	CEILING TILE	2007	651	65	5	65		65	18
19	INTERIOR DESIGN-CORRIDORS/DINING ROOM	2007	375	37	5	37		37	19
20	INTERIOR DESIGN-HEART FAILURE UNIT	2007	5,206	521	5	521		521	20
21	PROCUREMENT SERVICES-CORRIDORS/DINING ROOM	2007	8,520	852	5	852		852	21
22	ROOFTOP AC UNIT	2007	5,552	555	5	555		555	22
23	CARPETING-RESIDENT ROOMS	2007	13,136	1,314	5	1,314		1,314	23
24	FRAMED ARTWORK-CORRIDORS/DINING ROOM	2007	3,370	337	5	337		337	24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 7,578,438	\$ 233,568		\$ 262,944	\$ 29,376	\$ 3,274,915	34

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

**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	\$ 1,103,740	\$ 147,893	\$ 110,374	\$ (37,519)	10 YRS	\$ 642,095	71
72	Current Year Purchases	111,116	22,237	5,556	(16,681)	10 YRS	5,556	72
73	Fully Depreciated Assets	142,562					142,562	73
74	RELATED PARTY	2,553,881	22,773		(22,773)			74
75	TOTALS	\$ 3,911,299	\$ 192,903	\$ 115,930	\$ (76,973)		\$ 790,213	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)	\$ 11,489,737	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 426,471	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 378,874	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (47,597)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,065,128	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: N/A

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

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 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	<b>TOTAL</b>				\$			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: \$ 39,193 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	<b>TOTAL</b>		\$	\$	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. \_\_\_\_\_ /2008 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2009 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

\* 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><b>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</b></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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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	\$		\$ 10,184	\$		\$ 10,184	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			15,734			15,734	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			57			57	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				941,768		941,768	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	RADIOLOGY,LAB,RENTALS Other (specify):					506,666	209,518		716,184	13
14	<b>TOTAL</b>			\$		\$ 532,641	\$ 1,151,286		\$ 1,683,927	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 &amp; ID Number BALLARD NURSING CENTER

# 0023093

Report Period Beginning: 01/01/2007

Ending:

12/31/2007

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 831	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 107,312 )	4,849,596		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	175,321		6
7	Other Prepaid Expenses	35,647		7
8	Accounts Receivable (owners or related parties)	363,266		8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 5,424,661	\$	10
	<b>B. Long-Term Assets</b>			
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	892,250		15
16	Equipment, at Historical Cost	1,357,417		16
17	Accumulated Depreciation (book methods)	(1,186,885)		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>CD &amp; LEASE DEPOSIT</u>	107,061		23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 1,169,843	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 6,594,504	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 2,079,379	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,478,013		29
30	Accrued Salaries Payable	573,205		30
31	Accrued Taxes Payable (excluding real estate taxes)	89,888		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	11,703		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 5,232,188	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	989,738		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 989,738	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 6,221,926	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 372,578	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 6,594,504	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>239,053</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>239,053</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>133,525</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>133,525</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>372,578</b>	<b>24</b> *

\* 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	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 14,182,461	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 14,182,461	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,151,323	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,151,323	8
	<b>C. Other Operating Revenue</b>		
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	18,154	13
14	Non-Patient Meals	13,215	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 31,369	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	8,297	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 8,297	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>VENDING COMMISSIONS NET</b>	2,285	28
28a	<b>CRUISE GRANT</b>	50,000	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 52,285	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 15,425,735	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,827,021	31
32	Health Care	6,780,767	32
33	General Administration	3,284,020	33
	<b>B. Capital Expense</b>		
34	Ownership	1,589,703	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	1,683,927	35
36	Provider Participation Fee	126,473	36
	<b>D. Other Expenses (specify):</b>		
37	<b>OUT-OF-PERIOD EXPENSES</b>		37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 15,291,911	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	133,824	41
42	<b>Income Taxes</b>	(299)	42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 133,525	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.

TAX RETURN PREPARED ON CASH BASIS

\*\*\* 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: **01/01/2007**

Ending:

**12/31/2007**

**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	4,432	5,486	207,314	37.79	2
3	Registered Nurses	56,010	59,006	1,925,804	32.64	3
4	Licensed Practical Nurses	9,121	10,078	248,288	24.64	4
5	CNAs & Orderlies	90,876	98,537	1,654,720	16.79	5
6	CNA Trainees					6
7	Licensed Therapist	21,134	22,862	864,824	37.83	7
8	Rehab/Therapy Aides	38,720	41,711	1,095,376	26.26	8
9	Activity Director	3,876	4,222	65,846	15.60	9
10	Activity Assistants	8,922	9,465	103,793	10.97	10
11	Social Service Workers	5,411	5,795	122,706	21.17	11
12	Dietician					12
13	Food Service Supervisor	1,938	2,112	46,466	22.00	13
14	Head Cook					14
15	Cook Helpers/Assistants	30,082	32,794	353,574	10.78	15
16	Dishwashers					16
17	Maintenance Workers	6,286	6,680	87,787	13.14	17
18	Housekeepers	34,666	36,993	352,017	9.52	18
19	Laundry	5,820	6,638	79,531	11.98	19
20	Administrator	5,080	6,099	230,270	37.76	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	24,820	26,475	633,330	23.92	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	1,962	2,144	33,066	15.42	31
32	Other Health C: <u>WARD/PURCH</u>	5,710	6,200	64,731	10.44	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	354,866	383,297	\$ 8,169,443 *	\$ 21.31	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	M	\$ 6,385	1-3	35
36	Medical Director	O	116,800	9-3	36
37	Medical Records Consultant	N	4,224	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	5,700	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	30,000	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	1,172	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 164,281		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses		6,758	10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)		\$ 6,758		53

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
	ADMINISTRATOR		\$ 230,270	Workers' Compensation Insurance	\$ 106,425	IDPH License Fee	\$ 995		
	ASST ADMIN		0	Unemployment Compensation Insurance	55,301	Advertising: Employee Recruitment	7,429		
	OTHER ADMIN		0	FICA Taxes	582,395	Health Care Worker Background Check	1,540		
				Employee Health Insurance	579,228	(Indicate # of checks performed _____)			
				Employee Meals	0	Patient Background Checks	0		
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	8,085		
				EMPLOYEE BENEFITS - OTHER	12,609	MARKETING/ADV/PROMO	104,652		
						LICENSES/DUES/SUBSCRIPTIONS	30,774		
						MGMT CO ALLOC			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 230,270			TRUST/FRANCHISE/CONTRIB/ETC	(8,085)		
B. Administrative - Other				INSURANCE - EXECUTIVE LIFE	1,716	Less: Public Relations Expense	(4,561)		
Description			Amount	INSURANCE - EXECUTIVE LIFE VI 21	(1,716)	Non-allowable advertising	(98,714)		
MANAGEMENT FEES			\$ 306,700			Yellow page advertising	(1,377)		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 306,700	TOTAL (agree to Schedule V, line 22, col.8)	\$ 1,335,958	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 40,738		
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
			\$			\$	Out-of-State Travel	\$	
							In-State Travel	0	
							Seminar Expense	0	
							Entertainment Expense	( )	
							(agree to Sch. V, line 24, col. 8)		
SEE SCHEDULE ATTACHED			166,568	TOTAL			TOTAL		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 166,568						

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name & ID Number **BALLARD NURSING CENTER**# **0023093**Report Period Beginning: **01/01/2007**Ending: **12/31/2007****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 \$13,876
- (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. \$ 12,908 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 \$5,000, 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