

Facility Name & ID Number BALLARD NURSING CENTER

0023093 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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 N/A

	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			23,856	23,856	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	20,453	3,873		24,326	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,453	3,873	23,856	48,182	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 57.15%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

NONE

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 01/01/77

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

YES Date _____ NO

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

YES NO If YES, enter number of beds certified 145 and days of care provided 14,691

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/09

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

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
	A. General Services										
1	Dietary	480,410	37,278		517,688			517,688		1	
2	Food Purchase		228,534		228,534		(507)	228,027		2	
3	Housekeeping	395,348	77,200		472,548			472,548		3	
4	Laundry	88,787	63,330		152,117			152,117		4	
5	Heat and Other Utilities			284,994	284,994			284,994		5	
6	Maintenance	106,697	141,744	63,352	311,793			311,793		6	
7	Other (specify):*			23,459	23,459			23,459		7	
8	TOTAL General Services	1,071,242	548,086	371,805	1,991,133		(507)	1,990,626		8	
	B. Health Care and Programs										
9	Medical Director			180,800	180,800			180,800		9	
10	Nursing and Medical Records	5,016,616	459,751	110,456	5,586,823			5,586,823		10	
10a	Therapy	2,514,269		135,336	2,649,605			2,649,605		10a	
11	Activities	209,159	18,710	1,208	229,077		(12,725)	216,352		11	
12	Social Services	118,747		1,417	120,164			120,164		12	
13	CNA Training									13	
14	Program Transportation			1,298	1,298			1,298		14	
15	Other (specify):*									15	
16	TOTAL Health Care and Programs	7,858,791	478,461	430,515	8,767,767		(12,725)	8,755,042		16	
	C. General Administration										
17	Administrative	222,579		316,767	539,346		(39,607)	499,739		17	
18	Directors Fees									18	
19	Professional Services			159,281	159,281		4,652	163,933		19	
20	Dues, Fees, Subscriptions & Promotions			163,771	163,771		(123,253)	40,518		20	
21	Clerical & General Office Expenses	761,209	103,301	178,662	1,043,172		(214,298)	828,874		21	
22	Employee Benefits & Payroll Taxes			1,517,681	1,517,681		(1,716)	1,515,965		22	
23	Inservice Training & Education			14,274	14,274			14,274		23	
24	Travel and Seminar									24	
25	Other Admin. Staff Transportation			54,832	54,832		(16,776)	38,056		25	
26	Insurance-Prop.Liab.Malpractice			159,309	159,309			159,309		26	
27	Other (specify):*			36,540	36,540		(21,672)	14,868		27	
28	TOTAL General Administration	983,788	103,301	2,601,117	3,688,206		(412,670)	3,275,536		28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	9,913,821	1,129,848	3,403,437	14,447,106		(425,902)	14,021,204		29	

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	0
	REPAIRS & MAINTENANCE	0
		0
3	HOUSEKEEPING	
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	66,979
	ELECTRICITY	134,768
	WATER	75,428
	CABLE TV - LOBBY	7,819
		0
		284,994
6	MAINTENANCE	
	GROUNDS MAINTENANCE	41,624
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	0
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	16,093
	EXTERMINATING SERVICE	5,635
	FIRE SERVICE	0
		0
		0
		0
		0
		63,352
7	OTHER	
	SCAVENGER	23,459
	SECURITY SERVICE	0
		0
		0
		23,459
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	180,800
		180,800

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	100,895
	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	4,336
	PHARMACY CONSULTANT XVIII B 39-2	5,225
	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
		110,456
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	132,136
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	3,200
		135,336
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	1,208
		0
		1,208
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	1,417
		0
		1,417
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	1,298
		0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	316,767
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	32,847
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	126,434
		0
		159,281
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	270
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	117,253
	EMPLOYEE WANT ADS XIX F	5,271
	CONTRIBUTIONS VI 20 XIX F	5,730
	DUES & SUBSCRIPTIONS XIX F	22,897
	LICENSES & PERMITS XIX F	10,850
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	800
	PATIENT BACKGROUND CHECKS XIX F	700
		163,771
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	1,036
	PENALTIES / OVERDRAFT CHARGES VI 18	110,497
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	67,129
	MESSENGER SERVICE	0
		0
		178,662

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	727,346
	UNEMPLOYMENT COMPENSATION XIX D	35,782
	WORKERS COMPENSATION INSURANC XIX D	117,600
	HOSPITALIZATION INSURANCE XIX D	626,538
	EMPLOYEE BENEFITS - OTHER XIX D	8,699
	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
		1,517,681
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	14,274
		14,274
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	54,832
		54,832
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	159,309
		159,309
27	OTHER	
	BAD DEBTS VI 24	36,540
		36,540

GRAND TOTAL COLUMN 3 OTHER

3,403,437

**BALLARD NURSING CENTER
SCHEDULES
12/31/2009**

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

TOTAL FOOD PURCHASE	228,534	
LESS SALES TAX	<u>(507)</u>	HAVE YOU FORGOTTEN TO ENTER SALES TAX ON PAGE 5??
NET FOOD	228,027	
TOTAL PATIENT CENSUS	48,182	
TIME 3 MEALS PER DAY	<u>3</u>	
TOTAL PATIENT MEALS	144,546	
ADD # EMPLOYEE MEALS/DAY	0	
TIME # DAYS	<u>365</u>	
TOTAL EMPLOYEE MEALS	0	
PATIENT MEALS	144,546	
ADD EMPLOYEE MEALS	<u>0</u>	
TOTAL MEALS/YEAR	144,546	
NET FOOD	228,027	
DIVIDE TOTAL MEALS/YEAR	<u>144,546</u>	
COST PER MEAL	1.58	
TIME EMPLOYEE MEALS	<u>0</u>	
EMPLOYEE MEAL RECLASSIFICATION	0	
	=====	

Facility Name & ID Number

BALLARD NURSING CENTER

#0023093

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	
	D. Ownership											
30	Depreciation			59,610	59,610		59,610	447,405	507,015			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			142,635	142,635		142,635	530,144	672,779			32
33	Real Estate Taxes							464,294	464,294			33
34	Rent-Facility & Grounds			1,170,664	1,170,664		1,170,664	(1,170,664)				34
35	Rent-Equipment & Vehicles			29,689	29,689		29,689		29,689			35
36	Other (specify):*											36
37	TOTAL Ownership			1,402,598	1,402,598		1,402,598	271,179	1,673,777			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,681,117	469,472	2,150,589		2,150,589		2,150,589			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			126,474	126,474		126,474		126,474			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		1,681,117	595,946	2,277,063		2,277,063		2,277,063			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	9,913,821	2,810,965	5,401,981	18,126,767		18,126,767	(154,723)	17,972,044			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: **01/01/2009**

Ending: **12/31/2009**

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	BHF 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	65,452	30		9
10	Interest and Other Investment Income	(15,785)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(507)	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	(110,497)	21		18
19	Entertainment	(270)	20		19
20	Contributions	(5,730)	20		20
21	Owner or Key-Man Insurance	(1,716)	22		21
22	Special Legal Fees & Legal Retainers	(6,248)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(36,540)	27		24
25	Fund Raising, Advertising and Promotional	(117,253)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(133,302)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (362,396)		\$	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)	207,673		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 207,673		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (154,723)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

BALLARD NURSING CENTER

ID# 0023093

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1		\$		1
2	MARKETING SALARY	(103,801)	21	2
3	MARKETING TRAVEL	(16,776)	25	3
4	BARBER & BEAUTY INCOME	(12,725)	11	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(133,302)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BALLARD NURSING CENTER# 0023093

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	(507)	0	0	0	0	0	0	0	0	0	0	(507)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(507)	0	0	0	0	0	0	0	0	0	0	(507)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(12,725)	0	0	0	0	0	0	0	0	0	0	(12,725)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(12,725)	0	0	0	0	0	0	0	0	0	0	(12,725)	16
	C. General Administration													
17	Administrative	0	(39,607)	0	0	0	0	0	0	0	0	0	(39,607)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(6,248)	10,900	0	0	0	0	0	0	0	0	0	4,652	19
20	Fees, Subscriptions & Promotions	(123,253)	0	0	0	0	0	0	0	0	0	0	(123,253)	20
21	Clerical & General Office Expenses	(214,298)	0	0	0	0	0	0	0	0	0	0	(214,298)	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	(16,776)	0	0	0	0	0	0	0	0	0	0	(16,776)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(36,540)	14,868	0	0	0	0	0	0	0	0	0	(21,672)	27
28	TOTAL General Administration	(398,831)	(13,839)	0	(412,670)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(412,063)	(13,839)	0	(425,902)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BALLARD NURSING CENTER# 0023093

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	65,452	381,953	0	0	0	0	0	0	0	0	0	447,405	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(15,785)	545,929	0	0	0	0	0	0	0	0	0	530,144	32
33	Real Estate Taxes	0	464,294	0	0	0	0	0	0	0	0	0	464,294	33
34	Rent-Facility & Grounds	0	(1,170,664)	0	0	0	0	0	0	0	0	0	(1,170,664)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	49,667	221,512	0	271,179	37								
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(362,396)	207,673	0	0	0	0	0	0	0	0	0	(154,723)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ELI PICK	32.5	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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 RENT	\$ 1,170,664	BALLARD PARTNERS	100.00%	\$	\$ (1,170,664)	1
2	V							2
3	V	19 ACCOUNTING FEES				10,900	10,900	3
4	V	30 DEPRECIATION				380,697	380,697	4
5	V	32 INTEREST				545,929	545,929	5
6	V	33 REAL ESTATE TAXES				464,294	464,294	6
7	V							7
8	V	17 MANAGEMENT FEES	316,767	PICK MANAGEMENT GROUP	100.00%		(316,767)	8
9	V							9
10	V	17 SALARIES				277,160	277,160	10
11	V	27 PAYROLL TAXES				14,868	14,868	11
12	V	30 DEPRECIATION				1,256	1,256	12
13	V							13
14	Total		\$ 1,487,431			\$ 1,695,104	\$ * 207,673	14

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

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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	ADMIN	35.00	NONE	40	100.00	SALARY	\$ 138,580	17-7	1
2	ELI PICK	EXECUTIVE DIR	ADMIN	32.50	NONE	40	100.00	SALARY	138,580	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	\$ 277,160		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: 01/01/2009

Ending: 2/31/2009

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number

BALLARD NURSING CENTER

0023093

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
A. Directly Facility Related																	
Long-Term																	
1	M & T REALTY CAPITAL CORP	X		MORTGAGE	\$97,136.00	9/25/06	\$ 9,592,200	\$ 9,316,920	9/25/41	5.8200	\$ 545,929						
2																	
3																	
4																	
5																	
Working Capital																	
6	NEW CENTURY BANK	X		WORKING CAPITAL				2,512,351			127,635						
7	VARIOUS	X		CAPITAL LEASES				148,124			15,000						
8																	
9	TOTAL Facility Related				\$97,136.00		\$ 9,592,200	\$ 11,977,395			\$ 688,564						
B. Non-Facility Related*																	
10																	
11																	
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$			\$						
15	TOTALS (line 9+line14)						\$ 9,592,200	\$ 11,977,395			\$ 688,564						

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

1. Real Estate Tax accrual used on 2008 report.	\$	400,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	408,387	2
3. Under or (over) accrual (line 2 minus line 1).	\$	8,387	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	428,847	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	437,234	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2004	353,645	8
	2005	370,004	9
	2006	357,520	10
	2007	392,038	11
	2008	408,387	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2008	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

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

THE PAYMENT ON LINE 2 APPLIES TO THE 2008 TAX BILL

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.

4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u>408,387.48</u>	\$ <u>408,387.48</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 and 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 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

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.**

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).

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	\$ 96,557	35	\$ 90,514	\$ (6,043)	\$ 1,729,865
5			1994	995,072	25,515	35	25,515		398,672
6			1994	986,459	25,294	35	25,294		382,572
7			1995	101,526	2,603	35	2,603		37,852
8									
Improvement Type**									
9	VARIOUS		1980	2,955		20			2,955
10	VARIOUS		1981	11,619		20			11,619
11	VARIOUS		1982	17,413		20			17,413
12	VARIOUS		1984	3,536		20			3,536
13	VARIOUS		1985	8,040		20			8,040
14	VARIOUS		1986	18,668		20			18,668
15	VARIOUS		1987	42,109	772	20		(772)	42,109
16	VARIOUS		1988	15,834	350	20		(350)	15,834
17	VARIOUS		1990	4,990	158	20	250	92	4,938
18	VARIOUS		1991	155,172	2,599	20	5,145	2,546	155,172
19	VARIOUS		1992	54,689	1,274	20	2,734	1,460	47,647
20	VARIOUS		1993	1,571	50	20	77	27	1,290
21	HEATING COOLING SYSTEM		1996	2,312	59	20	116	57	1,576
22	INTERIOR SIGNS		1996	350	9	20	18	9	244
23	BUILDING IMPROVEMENTS		1996	70,114	1,798	20	3,506	1,708	47,623
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

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

Report Period Beginning:

01/01/2009

Ending:

12/31/2009**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)	\$ 1,195	37
38	MAV MOTOR REPLACEMENT	1996	2,000	51	20	100	49	1,358	38
39	INTERIOR SIGNS	1996	663	17	20	33	16	448	39
40	DRAPES	1996	616	16	20	31	15	421	40
41	COMP STATION CABLE	1996	2,566	66	20	128	62	1,739	41
42	HEATING AND COOLING SYSTEM	1997	2,999	77	20	150	73	1,850	42
43	SEWAGE PUMP	1997	2,498	64	20	125	61	1,583	43
44	CAULKING	1998	5,845	150	20	292	142	3,261	44
45	RENOVATION PATIOS	1998	6,134	157	20	307	150	3,531	45
46	A/C REPAIRS	1998	2,124	54	20	106	52	1,228	46
47	PARKING LOT	1998							47
48	ALARM SYSTEM	1998	2,500	64	20	125	61	1,490	48
49	SEWAGE PUMP	1998	2,498	64	20	125	61	1,500	49
50	A/C COUPLINGS	1998	2,905	74	20	145	71	1,692	50
51	PATIO FLOORS	1998	2,040	52	20	102	50	1,165	51
52	MOTOR	1998	1,544	40	20	77	37	911	52
53	SPRINKLER SYSTEM	1998	3,500	90	20	175	85	1,998	53
54	FAUCETS, COUPLINGS	1998	10,159	260	20	508	248	5,842	54
55	COMPRESSORS	1998	13,886	356	20	694	338	7,865	55
56	MEDICAL GAS PIPING	1999	124,600	3,195	20	6,230	3,035	66,973	56
57	ELECTRICAL WORK	1999	201,699	5,172	20	10,085	4,913	110,095	57
58	CHILLER REPLACEMENT	1999	76,355	1,958	20	3,818	1,860	40,725	58
59	AIR CARRIER	1999	693	18	20	35	17	353	59
60	CARPETING	1999	4,921	126	20	492	366	5,371	60
61	LOADING RAMP & PATIO	1999	127,175	3,261	20	6,359	3,098	68,359	61
62	SPRINKLER REPAIRS	1999	2,850	73	20	143	70	1,478	62
63	HEATING AND COOLING	1999	8,208	210	20	410	200	4,168	63
64	FLOW DEVICE OXYGEN	1999	1,760	45	20	88	43	939	64
65	ER GENER DESIGN	1999	11,614	298	20	568	270	6,248	65
66	DOOR CENSORS	1999	718	18	20	36	18	375	66
67	SIGNS	1999	18,235	468	20	912	444	9,728	67
68	METAL INCLOSURE	1999	934	24	20	47	23	470	68
69	PARKING AND AISLE PAVE	1999	65,443	1,678	20	3,272	1,594	34,703	69
70	TOTAL (lines 4 thru 69)		\$ 6,055,069	\$ 175,531		\$ 191,578	\$ 16,047	\$ 3,316,687	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:

01/01/2009

Ending:

12/31/2009**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 6,055,069	\$ 175,531		\$ 191,578	\$ 16,047	\$ 3,316,687	1
2	NURSE CALL SYSTEM	1999	49,222	1,262	20	2,461	1,199	26,046	2
3	LOAD RAMP DESIGN	1999	14,368	368	20	718	350	7,719	3
4	DOOR LOCKS	1999	2,781	71	20	139	68	1,436	4
5	FIRE PANEL	1999	978	25	20	49	24	519	5
6	NURSE CALL SYSTEM	2000	49,221	1,262	20	2,461	1,199	24,200	6
7	KEYLESS ENTRY SYSTEM	2000	1,250	32	20	62	30	612	7
8	ELECTRICAL OUTLETS	2000	7,600	195	20	380	185	3,546	8
9	VENTILATION BOILER	2000	5,696	146	20	284	138	2,604	9
10	WEIL MCLAIN BOILER	2000	50,425	1,293	20	2,521	1,228	20,588	10
11	HOT WATER BOILER	2000	9,172	235	20	459	224	3,978	11
12									12
13	TELEPHONE SYSTEM	1999	83,381	2,138	20	4,169	2,031	72,263	13
14	TELEPHONE SYSTEM ENHANCEMENT	2000	1,716	44	10	168	124	1,716	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)	10,413	18
19	COOLING COIL REPLACEMENT	2001	24,604	894	27.5	895	1	7,645	19
20									20
21	BOILER	2002	49,501	1,800	20	2,475	675	18,563	21
22	VALVES/BOOSTER PUMP	2002	2,430	88	20	122	34	915	22
23	DIALYSIS ROOM	2002	89,870	3,268	20	4,494	1,226	33,705	23
24	REMOVE & REPAPER	2002	10,972	399	20	549	150	4,117	24
25	FLOORING/DRAPERIES	2002	27,204		20	1,360	1,360	11,428	25
26									26
27	ELEV CAB REPLACEMENT	2003	6,850	249	27.5	249		1,608	27
28	REPAIR FLUE / REMOVE & REPLACE GREASE TRAP	2003	12,463	453	27.5	453		2,926	28
29	BLINDS	2003	1,760	64	27.5	64		413	29
30	REPAIR AIR HANDLER/REPLACE DIGITAL THERMOSTAT	2003	5,690	207	27.5	207		1,337	30
31	DOORS	2003	1,387	51	27.5	51		329	31
32	SIDEWALK REPAIRS	2003	800	29	27.5	29		188	32
33	HOT WATER BOILER	2003	29,001	1,055	27.5	1,055		7,165	33
34	TOTAL (lines 1 thru 33)		\$ 6,675,993	\$ 193,637		\$ 218,673	\$ 25,036	\$ 3,631,652	34

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

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

Report Period Beginning:

01/01/2009 Ending: 12/31/2009

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 6,675,993	\$ 193,637		\$ 218,673	\$ 25,036	\$ 3,631,652	1
2	CARPET	2004	5,459	617	5	272	(345)	5,459	2
3	SEWER LINE REPLACEMENT	2004	2,385	87	27.5	87		475	3
4	FIRE SUPPRESSION SYSTEM	2004	2,579	94	27.5	94		513	4
5	ELEVATOR CAB REPLACEMENT	2004	6,850	249	27.5	249		1,359	5
6	REPLACE SEWER LINE	2004	20,625	750	27.5	750		3,000	6
7	CARPETING	2005	57,619		27.5	2,095	2,095	9,340	7
8	PLUMBING	2005	1,636		27.5	59	59	263	8
9	WINDOW TREATMENT	2005	1,783		27.5	65	65	290	9
10	OXYGEN SYSTEM/DINING ROOM REMODEL	2005	610,957		27.5	22,217	22,217	99,051	10
11	CARPETING	2006	2,063	75	27.5	75		259	11
12	WALLCOVERING	2006	40,424	1,470	27.5	1,470		5,084	12
13	INTERIOR DESIGN-CORRIDORS/DINING ROOM	2006	6,716	244	27.5	244		844	13
14	INSTALL 2 TANK UNITS	2006	18,520	673	27.5	673		2,327	14
15	WINDOW TREATMENT	2007	12,525	2,505	5	2,505		6,262	15
16	CARPETING DINING ROOMS	2007	60,529	5,918	5	12,106	6,188	30,265	16
17	PAINT/WALLPAPER/TILE	2007	14,965	2,993	5	2,993		7,483	17
18	CEILING TILE	2007	651	130	5	130		325	18
19	INTERIOR DESIGN-CORRIDORS/DINING ROOM	2007	375	75	5	75		187	19
20	INTERIOR DESIGN - HEART FAILURE UNIT	2007	5,206	1,041	5	1,041		2,603	20
21	PROCUREMENT SERVICES - CORRIDORS/DINING ROOM	2007	8,520	1,704	5	1,704		4,260	21
22	ROOFTOP AC UNIT	2007	5,552	1,111	5	1,111		2,777	22
23	CARPETING - RESIDENT ROOMS	2007	13,136	2,627	5	2,627		6,568	23
24	FRAMED ARTWORK - CORRIDORS/DINING ROOM	2007	3,370	674	5	674		1,685	24
25	INTERIOR DESIGN - HEART FAILURE UNIT	2008	2,205	37	27.5	80	43	117	25
26	INTERIOR DESIGN - CORRIDORS/DIING ROOM	2008	3,551	59	27.5	129	70	188	26
27	CARPETING, TECNO FLOORING & BASES - RESIDENT	2008	44,527	742	27.5	1,619	877	2,361	27
28	COUNTERTOP AND LIGHTS	2008	1,882	31	27.5	68	37	99	28
29	PAINT/WALLPAPER/MIRROR	2009	5,038	168	15	168		168	29
30	CARPET/TILE BEDROOMS, WASHROOMS & OFFICES	2009	5,198	174	15	174		174	30
31	PLUMBING REPAIRS	2009	3,556	118	15	118		118	31
32	VACUUM PUMP & EXHAUST FAN FOR PUMP	2009	73,725	3,072	27.5	3,072		3,072	32
33	INTERIOR DESIGN LOBBY'S UPPER & LOWER, LOUNGES	2009	32,157	1,340	27.5	1,340		1,340	33
34	TOTAL (lines 1 thru 33)		\$ 7,750,277	\$ 222,415		\$ 278,757	\$ 56,342	\$ 3,829,968	34

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

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

0023093

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 7,750,277	\$ 222,415		\$ 278,757	\$ 56,342	\$ 3,829,968	1
2	FURNITURE FOR RESIDENT ROOMS	2009	70,612	2,942	27.5	2,942		2,942	2
3	INSULATION KITS FOR AROUND PIPES	2009	3,386	141	27.5	141		141	3
4	TV'S WITH MOUNTING BRACKETS	2009	11,923	497	27.5	497		497	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	TOTAL (lines 1 thru 33)		\$ 7,836,198	\$ 225,995		\$ 282,337	\$ 56,342	\$ 3,833,548	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	\$ 659,987	\$ 50,107	\$ 65,999	\$ 15,892	10 YRS	\$ 246,281	71
72	Current Year Purchases	45,213	9,043	2,261	(6,782)	10 YRS	2,261	72
73	Fully Depreciated Assets	323,157					323,157	73
74	RELATED PARTY	2,981,199	156,418	156,418				74
75	TOTALS	\$ 4,009,556	\$ 215,568	\$ 224,678	\$ 9,110		\$ 571,699	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)	\$ 11,845,754	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 441,563	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 507,015	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 65,452	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,405,247	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	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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

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: \$ 29,689 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* 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.

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2009 Ending: 12/31/2009
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>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>	<p>2. CLASSROOM PORTION:</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. CLINICAL PORTION:</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		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39-3	hrs	\$		\$	11,173	\$		\$	11,173	1
2	Licensed Speech and Language Development Therapist	39-3	hrs				25,080				25,080	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39-3	hrs				4,126				4,126	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 prescrpts					1,270,774			1,270,774	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	RADIOLOGY, LABS, RENTALS, OXYGEN Other (specify): MED SUPPLIES	39-2					429,093	410,343			839,436	13
14	TOTAL			\$		\$	469,472	1,681,117		\$	2,150,589	14

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

Facility Name & ID Number **BALLARD NURSING CENTER**# **0023093**Report Period Beginning: **01/01/2009**

Ending:

12/31/2009**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2009**

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,052	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>220,000</u>)	5,221,358		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	181,709		6
7	Other Prepaid Expenses	147,047		7
8	Accounts Receivable (owners or related parties)	1,713,540		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 7,264,706	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	13,792		15
16	Equipment, at Historical Cost	1,065,208		16
17	Accumulated Depreciation (book methods)	(891,687)		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 & LEASE DEPOSIT</u>	113,492		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 300,805	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,565,511	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,606,083	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,512,351		29
30	Accrued Salaries Payable	696,491		30
31	Accrued Taxes Payable (excluding real estate taxes)	132,894		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	5,591		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,953,410	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	904,992		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)	\$ 904,992	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,858,402	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 707,109	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,565,511	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 906,730	1
2	Restatements (describe):		2
3	POST CLOSING ADJUSTMENT	(63,657)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 843,073	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(135,964)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (135,964)	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)	\$ 707,109	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 16,710,467	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 16,710,467	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,255,563	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,255,563	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	12,725	13
14	Non-Patient Meals	8,432	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 21,157	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	15,785	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 15,785	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)		29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 18,002,972	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,991,133	31
32	Health Care	8,767,767	32
33	General Administration	3,688,206	33
B. Capital Expense			
34	Ownership	1,402,598	34
C. Ancillary Expense			
35	Special Cost Centers	2,150,589	35
36	Provider Participation Fee	126,474	36
D. Other Expenses (specify):			
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 18,126,767	40
41	Income before Income Taxes (line 30 minus line 40)**	(123,795)	41
42	Income Taxes	(12,169)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (135,964)	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: **01/01/2009**

Ending:

12/31/2009

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	1,928	2,168	\$ 107,005	\$ 49.36	1
2	Assistant Director of Nursing	2,517	2,517	122,995	48.87	2
3	Registered Nurses	53,316	54,794	2,229,059	40.68	3
4	Licensed Practical Nurses	14,246	14,762	460,924	31.22	4
5	CNAs & Orderlies	107,986	113,085	1,932,951	17.09	5
6	CNA Trainees					6
7	Licensed Therapist	18,131	19,816	886,850	44.75	7
8	Rehab/Therapy Aides	54,522	57,064	1,627,419	28.52	8
9	Activity Director	3,724	3,956	68,031	17.20	9
10	Activity Assistants	11,117	11,434	141,128	12.34	10
11	Social Service Workers	5,846	6,108	118,747	19.44	11
12	Dietician					12
13	Food Service Supervisor	1,928	2,064	55,424	26.85	13
14	Head Cook					14
15	Cook Helpers/Assistants	35,057	36,689	424,986	11.58	15
16	Dishwashers					16
17	Maintenance Workers	6,893	7,061	106,697	15.11	17
18	Housekeepers	37,882	39,188	395,348	10.09	18
19	Laundry	5,917	6,413	88,787	13.84	19
20	Administrator	3,344	3,714	207,584	55.89	20
21	Assistant Administrator	316	316	14,995	47.45	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	25,648	26,491	740,717	27.96	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	1,977	2,077	38,354	18.47	31
32	Other Health C: WARD/PURCH	7,941	8,275	125,328	15.15	32
33	Other(specify) RESEARCH STA	920	920	20,492	22.27	33
34	TOTAL (lines 1 - 33)	401,156	418,912	\$ 9,913,821 *	\$ 23.67	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	\$ 0	1-3	35
36	Medical Director	O	180,800	9-3	36
37	Medical Records Consultant	N	4,336	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	5,225	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	132,136	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	3,200	10a-3	43
44	Activity Consultant	E	1,208	11-3	44
45	Social Service Consultant	E	1,417	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 328,322		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			10-3	51
52	Certified Nurse Assistants/Aides	6,306	100,895	10-3	52
53	TOTAL (lines 50 - 52)	6,306	\$ 100,895		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function				Description	Amount	Description	Amount	
SUSAN AHLGREN	ADMINISTRATOR			Workers' Compensation Insurance	\$ 117,600	IDPH License Fee	\$ 995		
HAROLD HENNESSEY	ASST ADMIN			Unemployment Compensation Insurance	35,782	Advertising: Employee Recruitment	5,271		
				FICA Taxes	727,346	Health Care Worker Background Check	800		
				Employee Health Insurance	626,538	(Indicate # of checks performed 80)			
				Employee Meals	0	Patient Background Checks	70	700	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC		5,730	
				EMPLOYEE BENEFITS - OTHER	8,699	MARKETING/ADV/PROMO		117,523	
				EMPLOYEE PHYSICAL EXAMS	0	LICENSES/DUES/SUBSCRIPTIONS		32,752	
				PENSION/PROFIT SHARING PLANS	0	MGMT CO ALLOC			
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC		(5,730)	
				INSURANCE - EXECUTIVE LIFE	1,716	Less: Public Relations Expense		(270)	
				INSURANCE - EXECUTIVE LIFE VI 21	(1,716)	Non-allowable advertising		(117,253)	
						Yellow page advertising		(0)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)					\$ 222,579	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 40,518	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description				Description			Description		
Amount				Line #			Amount		
MANAGEMENT FEE							Out-of-State Travel		
\$ 316,767							\$		
							In-State Travel		
							0		
							Seminar Expense		
							0		
							Entertainment Expense		
							()		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)		
\$ 316,767				\$			\$		
C. Professional Services									
Vendor/Payee				Description					
Type				Line #					
Amount				Amount					
\$				\$					
SEE SCHEDULE ATTACHED									
159,281									
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)									
\$ 159,281									

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1	PAINT/DECORATING	\$		\$	\$	\$	\$ 0	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$ 0	\$	\$	\$	\$	\$

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 \$17,787
- (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? N/A
- (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. \$ 13,212 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. N/A
- (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. \$ 126,474
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. \$ N/A
 - 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: N/A
- (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.