



Facility Name & ID Number Harvard Memorial Hospital

# 8049116 Report Period Beginning: 7/1/2008 Ending: 6/30/09

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	45	Skilled (SNF)	45	16,425	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	45	TOTALS	45	16,425	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	1,694	4,497	4,062	10,253	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	1,694	4,497	4,062	10,253	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.42%

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

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

Meals on Wheels, Employee Meals

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 1976

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date March 2003 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 14 and days of care provided 3,804

Medicare Intermediary \_\_\_\_\_

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 06/30/09 Fiscal Year: 06/30/09

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

Facility Name & ID Number Harvard Memorial Hospital # 8049116 Report Period Beginning: 7/1/2008 Ending: 6/30/09

**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	400,096	33,021	155,708	588,825	(2,429)	586,396	(78,728)	507,668		1
2	Food Purchase										2
3	Housekeeping	188,224	26,505	38,462	253,191	(122)	253,069	(206,929)	46,140		3
4	Laundry	16,220	1,734	182	18,136		18,136	(9,433)	8,703		4
5	Heat and Other Utilities					329,059	329,059	(269,065)	59,994		5
6	Maintenance		390	842,267	842,657	(376,478)	466,179	(215,759)	250,420		6
7	Other (specify):* <b>Purchasing/Cent Supp</b>	62,933	(10,179)	1,330	54,084	(141)	53,943	(7,242)	46,701		7
8	<b>TOTAL General Services</b>	667,473	51,471	1,037,949	1,756,893	(50,111)	1,706,782	(787,156)	919,626		8
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	5,227,912	1,766,168	2,342,012	9,336,092	(6,174,187)	3,161,905	(205,097)	2,956,808		10
10a	Therapy	707,473	18,989	41,138	767,600	(15,057)	752,543	(101,034)	651,509		10a
11	Activities										11
12	Social Services										12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <b>Rad/Pharmacy</b>	1,315,233	182,132	1,092,284	2,589,649	(2,589,649)					15
16	<b>TOTAL Health Care and Programs</b>	7,250,618	1,967,289	3,475,434	12,693,341	(8,778,893)	3,914,448	(306,131)	3,608,317		16
	<b>C. General Administration</b>										
17	Administrative	47,203	3,016	254,940	305,159	(45,049)	260,110	(123,804)	136,306		17
18	Directors Fees										18
19	Professional Services					7,600	7,600	(3,617)	3,983		19
20	Dues, Fees, Subscriptions & Promotions					55,958	55,958	(26,634)	29,324		20
21	Clerical & General Office Expenses	328,289	5,762	524,306	858,357	(15,888)	842,469	(400,987)	441,482		21
22	Employee Benefits & Payroll Taxes			2,088,603	2,088,603	(289,223)	1,799,380	(1,464,909)	334,471		22
23	Inservice Training & Education										23
24	Travel and Seminar					28,463	28,463	(13,547)	14,916		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			67,200	67,200		67,200	(31,985)	35,215		26
27	Other (specify):* <b>Marketing,HR,Volunt</b>	7,865		651,852	659,717	(19,335)	640,382	(358,079)	282,303		27
28	<b>TOTAL General Administration</b>	383,357	8,778	3,586,901	3,979,036	(277,474)	3,701,562	(2,423,562)	1,278,000		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	8,301,448	2,027,538	8,100,284	18,429,270	(9,106,478)	9,322,792	(3,516,849)	5,805,943		29

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

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

Facility Name &amp; ID Number

Harvard Memorial Hospital

#8049116

Report Period Beginning:

7/1/2008

Ending:

6/30/09

## 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			1,319,313	1,319,313		1,319,313	(1,297,394)	21,919			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			911,048	911,048		911,048	(911,048)				32
33	Real Estate Taxes					55,640	55,640	(55,640)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles					45,116	45,116	(29,626)	15,490			35
36	Other (specify):* <b>Bad Debt</b>			1,477,555	1,477,555		1,477,555	(1,477,555)				36
37	<b>TOTAL Ownership</b>			3,707,916	3,707,916	100,756	3,808,672	(3,771,263)	37,409			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation					200	200		200			38
39	Ancillary Service Centers					8,980,884	8,980,884	(8,980,884)				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					24,638	24,638		24,638			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>					9,005,722	9,005,722	(8,980,884)	24,838			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	8,301,448	2,027,538	11,808,200	22,137,186		22,137,186	(16,268,996)	5,868,190			45

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



Harvard Memorial HospitalID# 8049116Report Period Beginning: 7/1/2008Ending: 6/30/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Dietary Expense not related to SNF care	\$ (78,728)	1
2	Housekeeping Expenses not related to SNF care	(206,929)	2
3	Laundry Expenses not related to SNF care	(9,433)	3
4	Heat & Other Utilities not related to SNF care	(269,065)	4
5	Maintenance Expenses not related to SNF care	(215,759)	5
6	Central Supply Expense not related to SNF care	(7,242)	6
7	Nursing & Medical Records Expenses not related to SNF	(205,097)	7
8	Therapy Expenses not related to SNF care	(101,034)	8
9	Administrative Expenses not related to SNF care	(123,804)	9
10	Professional Services not related to SNF care	(3,617)	10
11	Dues, Fees & Subscriptions not related to SNF care	(26,634)	11
12	Clerical & General Office Expense not related to SNF	(400,987)	12
13	Employee Benefits & Payroll Taxes not related to SNF	(1,464,909)	13
14	Travel & Seminar Expense not related to SNF care	(13,547)	14
15	Insurance Expenses not related to SNF care	(31,985)	15
16	Human Resources & Marketing Expense not related to SN	(358,079)	16
17	Depreciation Expense not related to SNF care	(1,297,394)	17
18	Interest Expense not related to SNF care	(911,048)	18
19	Real Estate Taxes not related to SNF care	(55,640)	19
20	Rent Expense-Equipment not related to SNF care	(29,626)	20
21	Ancillary Services related to Acute not SNF Operations	(8,980,884)	21
22	Bad Debt Expense	(1,477,555)	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>	(16,268,996)	49





**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mercy Health System	100			Mercy Hospital	Janesville	Hospital
				Mercy Assisted Care	Janesville	Includes Homecare
				Mercy Alliance	Janesville	Parent Corporation
				Mercy Walworth Hosp	Lake Geneva	Hospital

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

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

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

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

Facility Name &amp; ID Number

Harvard Memorial Hospital

#

8049116

Report Period Beginning:

7/1/2008

Ending:

6/30/09

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

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

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

Facility Name & ID Number Harvard Memorial Hospital

# 8049116

Report Period Beginning:

7/1/2008

Ending: 6/30/09

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 Mercy Health System  
 Street Address 1000 Mineral Point Avenue  
 City / State / Zip Code Janesville, WI 53546  
 Phone Number (608)756-6000  
 Fax Number (608)741-7368

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	6	Maintenance	Hours Worked	50,075	3	\$ 1,197,763	\$ 1,197,763	8,458	\$ 202,311	1
2	27	Marketing	Hours Worked	45,284	5	1,043,940	1,043,940	2,965	68,363	2
3	21	Information Systems	Hours Worked	124,631	4	3,625,391	3,625,391	2,504	72,840	3
4	21	Finance	Hours Worked	48,335	6	1,352,762	1,352,762	4,337	121,380	4
5	27	Human Resources	Hours Worked	43,382	4	1,096,504	1,096,504	4,919	124,318	5
6	21	Business Office	Hours Worked	21,191	2	2,971,676	2,971,676	1,227	172,067	6
7	17	Executive Salaries	Hours Worked	42,837	4	4,920,938	4,920,938	783	90,000	7
8	22	Pension Expense	Actual Expense	1	1	277,641	0	1	277,641	8
9	22	Worker's Compensation	FTE's	3,123	5	1,130,112	55,956	155	55,956	9
10	26	Gen/Prof Liability Insurance	Actual Expense	1	1	67,200	0	1	67,200	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					\$ 17,683,927	\$ 16,264,930		\$ 1,252,076	25

Facility Name & ID Number

Harvard Memorial Hospital

# 8049116

Report Period Beginning:

7/1/2008

Ending:

6/30/09

**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	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1	1998 Bond Issue	x		Medical Clinic Construction	\$75,000 annual	1998	\$ 1,750,000	\$ 1,005,000		\$ 12,207	1								
2	Mercy Alliance Loans	x		Hospital Renovations	Varies	2003	5,570,000	10,307,908		543,762	2								
3	Interentity Bond Payable 2005	x		Intercompany LT Payable	Varies	2005	3,901,107	7,089,997		355,079	3								
4											4								
5											5								
<b>Working Capital</b>																			
6											6								
7											7								
8											8								
9	<b>TOTAL Facility Related</b>						\$ 11,221,107	\$ 18,402,905		\$ 911,048	9								
<b>B. Non-Facility Related*</b>																			
10											10								
11											11								
12											12								
13											13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$		\$	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 11,221,107	\$ 18,402,905		\$ 911,048	15								

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

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

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

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

**B. Real Estate Taxes**

		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and		
1. Real Estate Tax accrual used on 2008 report.			\$	<b>1</b>
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>2</b>
3. Under or (over) accrual (line 2 minus line 1).			\$	<b>3</b>
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<b>4</b>
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>			\$	<b>5</b>
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>			\$	<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	<b>7</b>
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2004	_____	<b>8</b>	
	2005	_____	<b>9</b>	
	2006	_____	<b>10</b>	
	2007	_____	<b>11</b>	
	2008	_____	<b>12</b>	
<b>N/A - Hospital Property is Classified as Not For Profit - Tax Exempt</b>				
				<b>FOR BHF USE ONLY</b>
	<b>13</b>	FROM R. E. TAX STATEMENT FOR 2008	\$	<b>13</b>
	<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
	<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
	<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**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.**



Facility Name & ID Number Harvard Memorial Hospital

# 8049116

Report Period Beginning:

7/1/2008

Ending:

6/30/09

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 81,817 B. General Construction Type: Exterior Brick Frame Block Number of Stories 2

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

---

---

---

---

---

---

---

---

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

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_

3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

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

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Hospital/SNF</u>	<u>85,800</u>	<u>1956</u>	<u>\$ 3,452</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>85,800</b>		<b>\$ 3,452</b>	<b>3</b>

**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				\$	\$		\$	\$	\$
5		SNF - original building cannot be broken out from original hospital building costs							
6									
7									
8									
<b>Improvement Type**</b>									
9	Metal Lockers		1976	771		20			771
10	Door Alarm System		1989	1,055		10			1,055
11	Wiring for CC Phones		1990	418		10			418
12	Activities Office		1996	19,981	1,332	15	1,332		16,761
13	A/C Compressor		1996	1,922	128	15	128		1,700
14	Cabinets		1996	11,214	561	20	561		7,340
15	Wandergard		1999	2,652	265	10	265		5,629
16	Construct Firewall		2003	3,761	251	15	251		1,379
17	Skilled Care Nurse Station		2004	9,522	635	15	635		3,491
18	Top Upper Cabinet		2005	1,979	198	10	198		891
19	Care Center Wiring		2005	305	43	7	43		196
20	Paint Rooms		2006	20,000	2,000	10	2,000		5,000
21	Water Heater		2007	8,620	862	10	862		2,155
22	Care Center Circ Line Plumbing		2008	4,676	468	10	468		701
23	Network Drops		2008	555	55	5	111	56	55
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 **Harvard Memorial Hospital**

# **8049116**

Report Period Beginning:

**7/1/2008**

Ending:

**6/30/09**

**XI. OWNERSHIP COSTS (continued)**

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ <b>87,431</b>	\$ <b>6,798</b>		\$ <b>6,854</b>	\$ <b>56</b>	\$ <b>47,542</b>	<b>70</b>

\*\*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	\$ 142,154	\$ 12,693	\$ 12,693	\$		\$ 57,079	71
72	Current Year Purchases	69,333	2,428	2,428			2,428	72
73	Fully Depreciated Assets	114,261					114,261	73
74								74
75	TOTALS	\$ 325,748	\$ 15,121	\$ 15,121	\$		\$ 173,768	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		N/A								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)	\$ 416,631	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 21,919	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 21,975	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 56	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 221,310	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Building	\$ 15,907,085	\$ 530,771	\$ 8,310,005	86
87	Equipment	8,162,452	518,038	5,668,861	87
88	Land Improvements	679,675	24,290	422,125	88
89					89
90					90
91	TOTALS	\$ 24,749,212	\$ 1,073,099	\$ 14,400,991	91

G. Construction-in-Progress

	Description	Cost	
92	None	\$	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: All rental equipment is short term rental

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

If NO, see instructions.  YES  NO

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

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: \$ 2,261 Description: \$727 Accucheck Meter/\$1252 Copier Rental/\$282 Helium Rental

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2012 \$ \_\_\_\_\_

\* 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>
--	---	--

**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		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): <u>N/A All paid as Staff wages</u>									13
14	TOTAL			\$		\$	\$		\$	14

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

Facility Name & ID Number Harvard Memorial Hospital# 8049116Report Period Beginning: 7/1/2008

Ending:

6/30/09

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of

6/30/09

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 857,525	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>5,771,335</u> )	3,826,574		3
4	Supply Inventory (priced at )	666,711		4
5	Short-Term Investments			5
6	Prepaid Insurance	93,870		6
7	Other Prepaid Expenses	61,849		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 5,506,529	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	902,279		13
14	Buildings, at Historical Cost	15,994,517		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	8,488,200		16
17	Accumulated Depreciation (book methods)	(14,619,302)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Debt Issuance Costs</u>	100,440		23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 10,866,134	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 16,372,663	\$	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 311,833	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	664,570		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	28,308		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	(3,131)		35
<b>Other Current Liabilities(specify):</b>				
36	<u>Other Current Liabilities</u>	(83,808)		36
37	<u>Third Party Payables</u>	85,156		37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 1,002,928	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	18,402,905		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)	\$ 18,402,905	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 19,405,833	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (3,033,170)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 16,372,663	\$	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>(3,392,822)</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>(3,392,822)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>359,652</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>359,652</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>(3,033,170)</b>	<b>24</b> *

\* This must agree with page 17, line 47.

Facility Name & ID Number Harvard Memorial Hospital# 8049116Report Period Beginning: 7/1/2008Ending: 6/30/09

**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	\$ 47,539,089	1
2	Discounts and Allowances for all Levels	(25,201,802)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 22,337,287</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$</b>	<b>8</b>
<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		13
14	Non-Patient Meals	102,096	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	46,152	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 148,248</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions	598	24
25	Interest and Other Investment Income***	9,147	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 9,745</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Rent and Misc Non Op Revenue	7,068	28
28a	Loss on Equipment Disposal	(5,510)	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 1,558</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 22,496,838</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	2,171,811	31
32	Health Care	11,855,817	32
33	General Administration	4,401,642	33
<b>B. Capital Expense</b>			
34	Ownership	2,230,361	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37	Bad Debt	1,477,555	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 22,137,186</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>359,652</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 359,652</b>	<b>43</b>

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

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

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

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

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

# **8049116**

Report Period Beginning:

**7/1/2008**

Ending:

**6/30/09**

**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	3,608	4,160	\$ 191,822	\$ 46.11	1
2	Assistant Director of Nursing					2
3	Registered Nurses	74,483	82,774	3,351,434	40.49	3
4	Licensed Practical Nurses	3,538	3,853	76,155	19.77	4
5	CNAs & Orderlies	29,580	33,516	478,265	14.27	5
6	CNA Trainees					6
7	Licensed Therapist	15,563	17,680	627,635	35.50	7
8	Rehab/Therapy Aides	2,143	2,145	20,859	9.72	8
9	Activity Director	1,896	2,077	34,352	16.54	9
10	Activity Assistants	2,815	3,208	45,013	14.03	10
11	Social Service Workers	2,208	2,688	62,237	23.15	11
12	Dietician	2,967	3,334	77,810	23.34	12
13	Food Service Supervisor	3,630	4,484	86,203	19.22	13
14	Head Cook	1,697	1,945	29,868	15.36	14
15	Cook Helpers/Assistants	19,405	21,564	217,954	10.11	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	14,105	15,899	195,180	12.28	18
19	Laundry	1,433	1,684	17,020	10.11	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	12,897	14,631	310,160	21.20	22
23	Office Manager					23
24	Clerical	16,044	18,143	276,779	15.26	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	776	776	44,652	57.54	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	15,492	17,780	370,423	20.83	31
32	Other Health Care(specify)	57,901	63,977	1,787,628	27.94	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	282,181	316,318	\$ 8,301,449 *	\$ 26.24	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$		35
36	Medical Director			36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant			39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	\$ 81	5,073	10-3	50
51	Licensed Practical Nurses	24	1,211	10-3	51
52	Certified Nurse Assistants/Aides	1,537	41,238	10-3	52
53	TOTAL (lines 50 - 52)	1,642	\$ 47,522		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	
Clerical Staff	Clerical	0	\$ 47,203	Workers' Compensation Insurance	\$ 57,165	IDPH License Fee	\$	
				Unemployment Compensation Insurance	18,715	Advertising: Employee Recruitment		
				FICA Taxes	611,161	Health Care Worker Background Check		
				Employee Health Insurance	980,128	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Memberships & Dues	48,810	
				Life & Disability Insurance	38,696	Misc Promotional	4,129	
				Pension	277,641	Publications	3,019	
				Employer TDA Match	79,329	Allocated to Non SNF Areas	(26,634)	
				Accrued Paid Leave	13,806			
				Employee Health & Other Benefits	11,962	Less: Public Relations Expense	( )	
				Allocated to Ancillary Centers	(289,223)	Non-allowable advertising	( )	
				Allocated to Non SNF Areas	(1,464,909)	Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 47,203	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 334,471		\$ 29,324		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Hospital Assessment Tax			\$ 194,364			\$	Out-of-State Travel	\$
Membership & Dues			36,218					
Admin Salaries/Interco Rent (net)			(27,240)					
Other Allocations			51,598				In-State Travel	28,463
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 254,940				Seminar Expense	
							Allocated to Non SNF Areas	(13,547)
							Entertainment Expense	( )
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 14,916
C. Professional Services				TOTAL				
Vendor/Payee	Type		Amount	\$				
WIPFLI	Audit Fees		\$ 5,000					
WIPFLI	Cost Report Prep		1,000					
IL Charity Bureau	Annual Return		100					
Virchow Krause	Tax Returns		1,500					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 7,600					

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name & ID Number Harvard Memorial Hospital# 8049116Report Period Beginning: 7/1/2008Ending: 6/30/09**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO  
If YES, give association name and amount. \_\_\_\_\_
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 15
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ N/A Line \_\_\_\_\_
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 24,638  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ NONE Has any meal income been offset against related costs? YES Indicate the amount. \$ 102,096
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? N/A  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
**g. Does the facility transport residents to and from day training? NO**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? YES  
Firm Name: WIPFLI
- (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? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.