



Facility Name & ID Number Hamilton Memorial Nursing and Rehabilitation Center

# 0051292 Report Period Beginning: 05/17/2011 Ending: 12/31/2011

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	56	Skilled (SNF)	56	12,768	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	56	TOTALS	56	12,768	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	4 Other	5 Total		
8	SNF	7,253	2,736	494	10,483	8	
9	SNF/PED					9	
10	ICF					10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	7,253	2,736	494	10,483	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.10%

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 5/17/2011

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

YES  Date 5/17/2011 NO

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

YES  NO  If YES, enter number of beds certified 56 and days of care provided 494

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011

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

Facility Name & ID Number Hamilton Memorial Nursing and Rehabilitati # 0051292 Report Period Beginning: 05/17/2011 Ending: 12/31/2011

**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	102,163	9,341	435	111,939		111,939	(563)	111,376		1
2	Food Purchase		47,502		47,502		47,502		47,502		2
3	Housekeeping	11,126	6,395	43,500	61,021		61,021		61,021		3
4	Laundry		4,938	42,574	47,512		47,512		47,512		4
5	Heat and Other Utilities			51,601	51,601		51,601		51,601		5
6	Maintenance	21,088	9,713	28,069	58,870		58,870		58,870		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	134,377	77,889	166,179	378,445		378,445	(563)	377,882		8
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	470,498	32,440	2,154	505,092		505,092		505,092		10
10a	Therapy		5,027	94,422	99,449		99,449		99,449		10a
11	Activities	13,169	129	1,052	14,350		14,350		14,350		11
12	Social Services	18,174	43	1,052	19,269		19,269		19,269		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	501,841	37,639	98,680	638,160		638,160		638,160		16
	<b>C. General Administration</b>										
17	Administrative	38,835			38,835		38,835		38,835		17
18	Directors Fees										18
19	Professional Services			90,709	90,709		90,709	(75,480)	15,229		19
20	Dues, Fees, Subscriptions & Promotions			4,725	4,725		4,725		4,725		20
21	Clerical & General Office Expenses	18,495	10,154	12,425	41,074		41,074	37,625	78,699		21
22	Employee Benefits & Payroll Taxes			146,977	146,977		146,977		146,977		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,586	1,586		1,586		1,586		24
25	Other Admin. Staff Transportation			3,829	3,829		3,829		3,829		25
26	Insurance-Prop.Liab.Malpractice			59,435	59,435		59,435		59,435		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	57,330	10,154	319,686	387,170		387,170	(37,855)	349,315		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	693,548	125,682	584,545	1,403,775		1,403,775	(38,418)	1,365,357		29

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

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

Facility Name & ID Number Hamilton Memorial Nursing and Rehabilitation Center #0051292 Report Period Beginning: 05/17/2011 Ending: 12/31/2011

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			835	835		835	9,774	10,609			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,091	4,091		4,091	6,713	10,804			32
33	Real Estate Taxes			14,000	14,000		14,000		14,000			33
34	Rent-Facility & Grounds			105,000	105,000		105,000	(103,386)	1,614			34
35	Rent-Equipment & Vehicles			735	735		735	765	1,500			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			124,661	124,661		124,661	(86,134)	38,527			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		30,058	1,495	31,553		31,553		31,553			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			19,624	19,624		19,624		19,624			42
43	Other (specify):*		690	(2,851)	(2,161)		(2,161)	3,493	1,332			43
44	<b>TOTAL Special Cost Centers</b>		30,748	18,268	49,016		49,016	3,493	52,509			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	693,548	156,430	727,474	1,577,452		1,577,452	(121,059)	1,456,393			45

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

**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(563)	1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(2,399)	21		19
20	Contributions	(2,500)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	3,493	43		24
25	Fund Raising, Advertising and Promotional	(8,878)	19		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Employee Entertainment	(2,399)	21		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (13,246)		\$	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	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(110,212)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (110,212)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (123,458)		37

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

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

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

<b>BHF USE ONLY</b>							
48		49		50		51	52

Hamilton Memorial Nursing and Rehabilitation Center

ID# 0051292

Report Period Beginning: 05/17/2011

Ending: 12/31/2011

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

	\$		
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			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	0		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Hamilton Memorial Nursing and Rehabilitation Center# 0051292

Report Period Beginning:

05/17/2011

Ending:

12/31/2011

## 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	(563)	0	0	0	0	0	0	0	0	0	0	(563)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(563)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(563)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(8,878)	(66,602)	0	0	0	0	0	0	0	0	0	(75,480)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(4,899)	42,524	0	0	0	0	0	0	0	0	0	37,625	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(13,777)</b>	<b>(24,078)</b>	<b>0</b>	<b>(37,855)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(14,340)</b>	<b>(24,078)</b>	<b>0</b>	<b>(38,418)</b>	<b>29</b>								

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Hamilton Memorial Nursing and Rehabilitation Center# 0051292

Report Period Beginning:

05/17/2011 Ending:12/31/2011

## 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)	
	<b>D. Ownership</b>													
30	Depreciation	0	9,774	0	0	0	0	0	0	0	0	0	9,774	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	6,713	0	0	0	0	0	0	0	0	0	6,713	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(103,386)	0	0	0	0	0	0	0	0	0	(103,386)	34
35	Rent-Equipment & Vehicles	0	765	0	0	0	0	0	0	0	0	0	765	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>0</b>	<b>(86,134)</b>	<b>0</b>	<b>(86,134)</b>	<b>37</b>								
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	3,493	0	0	0	0	0	0	0	0	0	0	3,493	43
44	<b>TOTAL Special Cost Centers</b>	<b>3,493</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>3,493</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(10,847)	(110,212)	0	0	0	0	0	0	0	0	0	(121,059)	45

**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Buildings and Fixtures	\$	Walnut Creek Mgt. Co, LLC	100.00%	\$ 1,614	\$ 1,614	1
2	V	35 Moveable Equipment		Walnut Creek Mgt. Co, LLC	100.00%	765	765	2
3	V	21 Non-Capital		Walnut Creek Mgt. Co, LLC	100.00%	40,585	40,585	3
4	V	34 Rent	105,000	TI - McLeansboro, LLC	100.00%		(105,000)	4
5	V	30 Depreciation		TI - McLeansboro, LLC	100.00%	9,774	9,774	5
6	V	32 Interest		TI - McLeansboro, LLC	100.00%	6,713	6,713	6
7	V	21 A&G		TI - McLeansboro, LLC	100.00%	1,939	1,939	7
8	V	19 Management Fees	66,602	Walnut Creek Mgt. Co, LLC	100.00%		(66,602)	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 171,602			\$ 61,390	\$ * (110,212)	14

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



Facility Name & ID Number Hamilton Memorial Nursing and Rehabilitat # 0051292 Report Period Beginning: 05/17/2011 Ending: 12/31/2011

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											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 Hamilton Memorial Nursing and Rehabilitation Center # 0051292 Report Period Beginning: 05/17/2011 Ending: 2/31/2011

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 Tutera Health Care Services Consolidated  
 Street Address 7611 State Line Road, Suite 301  
 City / State / Zip Code Kansas City, MO  
 Phone Number ( 8164440900  
 Fax Number ( 8164440900

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	21	Non-Capital	Direct Costs	139,061,893	23	\$ 6,112,115	\$ 0	923,386	\$ 40,585	1
2	34	Capital Building	Direct Costs	139,061,893	23	242,995	0	923,386	1,614	2
3	35	Capital Equipment	Direct Costs	139,061,893	23	115,171	0	923,386	765	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					\$ 6,470,281	\$		\$ 42,964	25

Facility Name & ID Number

Hamilton Memorial Nursing and Rehabilitati

# 0051292

Report Period Beginning:

05/17/2011

Ending:

12/31/2011

**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										1									
2										2									
3										3									
4										4									
5										5									
<b>Working Capital</b>																			
6										6									
7										7									
8										8									
9	<b>TOTAL Facility Related</b>				\$	\$			\$	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>				\$	\$			\$	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, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>				
1. Real Estate Tax accrual used on 2010 report.		\$		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.)		\$		2		
3. Under or (over) accrual (line 2 minus line 1).		\$		3		
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>14,000</b>	4		
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		5		
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6		
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>14,000</b>	7		
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2006	_____	8	<b>FOR BHF USE ONLY</b>		
	2007	_____	9			
	2008	_____	10			
	2009	_____	11			
	2010	_____	12			
<b>This is a new facility. Hence there is no property tax history. Current year amounts were estimated</b>				13	FROM R. E. TAX STATEMENT FOR 2010 \$	13
				14	PLUS APPEAL COST FROM LINE 5 \$	14
				15	LESS REFUND FROM LINE 6 \$	15
				16	AMOUNT TO USE FOR RATE CALCULATION \$	16

**NOTES:**

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



**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 14,923 B. General Construction Type: Exterior Brick Frame Wood/Steel Number of Stories 1

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).

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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>Nursing Facility</u>		<u>2011</u>	<u>\$ 28,500</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>			<b>\$ 28,500</b>	<b>3</b>

**XI. OWNERSHIP COSTS (continued)**

**B. Building and Improvement Costs-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	56	2011		\$ 399,000	\$ 5,816	40	\$ 5,816	\$	\$ 5,816	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Therapy Room	2011		72,554	302	20	302		302	9
10	Laundry Room	2011		6,983	217	10	217		217	10
11	Water Heater	2011		6,365	578	10	578		737	11
12	Kronos Time Clock System	2011		2,948	172	10	172		319	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

\*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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 487,850	\$ 7,085		\$ 7,085	\$	\$ 7,391	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$	\$	\$	\$		\$	71
72	Current Year Purchases	47,500	3,958	3,958		5	3,958	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 47,500	\$ 3,958	\$ 3,958	\$		\$ 3,958	75

D. Vehicle Costs. (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)	\$ 563,850	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 11,043	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 11,043	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 11,349	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: \_\_\_\_\_

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: \$ \_\_\_\_\_ Description: \_\_\_\_\_  
(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.	<u>/2012</u>	\$ _____
13.	<u>/2013</u>	\$ _____
14.	<u>/2014</u>	\$ _____

\* 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	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
							Units	Cost								
1	Licensed Occupational Therapist	10a Column 3	hrs	\$	2,213	\$ 35,857	\$ 0	2,213	\$ 35,857							1
2	Licensed Speech and Language Development Therapist	10a Column 3	hrs		1,198	19,406	0	1,198	19,406							2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	10a Column 3	hrs		2,417	39,159	5,027	2,417	44,186							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):															13
14	<b>TOTAL</b>			\$	5,828	\$ 94,422	\$ 5,027	5,828	\$ 99,449							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 **Hamilton Memorial Nursing and Rehabilitation Center**

# **0051292**

Report Period Beginning: **05/17/2011**

Ending: **12/31/2011**

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **12/31/2011** (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 13,662	\$	1
2	Cash-Patient Deposits	2,433		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	558,701		3
4	Supply Inventory (priced at )	12,260		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	58,086		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <b>Other</b>	70		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 645,212	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	125,544		15
16	Equipment, at Historical Cost	9,583		16
17	Accumulated Depreciation (book methods)	(1,375)		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):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 133,752	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 778,964	\$	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 166,897	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,608		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	68,362		30
31	Accrued Taxes Payable (excluding real estate taxes)	22,433		31
32	Accrued Real Estate Taxes(Sch.IX-B)	14,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 278,300	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	746,090		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 (sum of lines 39 thru 44)</b>	\$ 746,090	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,024,390	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (245,426)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 778,964	\$	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>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>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(245,426)	<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>	\$ (245,426)	<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>	\$ (245,426)	<b>24</b> *

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

Facility Name & ID Number Hamilton Memorial Nursing and Rehabilitation Center # 0051292 Report Period Beginning: 05/17/2011Ending: 12/31/2011**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	\$ 1,140,976	1
2	Discounts and Allowances for all Levels	(63,597)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 1,077,379</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	200,242	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 200,242</b>	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	451	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	563	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	33,998	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	18,426	19
20	Radiology and X-Ray		20
21	Other Medical Services	962	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 54,400</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	5	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 5</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 1,332,026</b>	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	378,445	31
32	Health Care	638,160	32
33	General Administration	387,170	33
<b>B. Capital Expense</b>			
34	Ownership	124,661	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	49,016	35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 1,577,452</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(245,426)</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (245,426)</b>	43

\* 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 **Hamilton Memorial Nursing and Rehabilitation Center**

# **0051292**

Report Period Beginning: **05/17/2011**

Ending:

**12/31/2011**

**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	2,771	2,907	\$ 71,599	\$ 24.63	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,362	1,362	26,615	19.54	3
4	Licensed Practical Nurses	8,619	8,619	148,734	17.26	4
5	CNAs & Orderlies	19,785	21,420	223,362	10.43	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,205	1,329	13,169	9.91	9
10	Activity Assistants					10
11	Social Service Workers	1,176	1,272	18,174	14.29	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	8,403	9,112	102,163	11.21	15
16	Dishwashers					16
17	Maintenance Workers	1,781	1,855	21,088	11.37	17
18	Housekeepers					18
19	Laundry	1,011	1,349	11,126	8.25	19
20	Administrator	1,232	1,232	38,835	31.52	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,240	1,240	13,889	11.20	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		80	4,794	59.93	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	48,585	51,777	\$ 693,548 *	\$ 13.39	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		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		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	
Kelly Boggess	Administrator	0	\$ 38,835	Workers' Compensation Insurance	\$	IDPH License Fee	\$	
				Unemployment Compensation Insurance		Advertising: Employee Recruitment	2,428	
				FICA Taxes		Health Care Worker Background Check (Indicate # of checks performed _____)		
				Employee Health Insurance		Patient Background Checks		
				Employee Meals		Admin/ Licenses	1,780	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	517	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 38,835					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount			Less: Public Relations Expense	( )	
None			\$			Non-allowable advertising	( )	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$			TOTAL (agree to Sch. V, line 20, col. 8)		
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Walnut Creek Mgt	Management Fees		\$ 66,602			\$	Out-of-State Travel	\$
NA	Legal Fees		729					
TFG/Gottlieb	Accounting Fees		(2,321)				In-State Travel	
Galaxy E Health Services	Data Processing		14,702					
Pinnacle Consulting	Professional Services		2,119				Seminar Expense	
Yellow Pages/Various	Advertising Other		8,878				Admin/Gen Travel & Seminar	1,586
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 90,709	TOTAL		\$	Entertainment Expense	( )
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 1,586

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name & ID Number Hamilton Memorial Nursing and Rehabilitation Center# 0051292Report Period Beginning: 05/17/2011 Ending: 12/31/2011**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? NA
- (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? NA  
What was the average life used for new equipment added during this period? NA
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 4,009 Line 10
- (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. \$ 19,624  
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? Yes Indicate the amount. \$ 563
- (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. \$ NA  
c. What percent of all travel expense relates to transportation of nurses and patients? NA  
d. Have vehicle usage logs been maintained? NA  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NA  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? NA  
**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. \$ NA**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: NA
- (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? NA  
Attach invoices and a summary of services for all architect and appraisal fees.