FOR BHF USE

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0023093

Facility Name: BALLARD NURSING CENTER

Address: 9300 BALLARD ROAD (Number) DES PLAINES (City) 60016 (Zip Code)

County: COOK

Telephone Number: 847 294-2300 **Fax #** 847 299-4012

HFS ID Number:

Date of Initial License for Current Owners: 01/01/1977

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: HAROLD D BLACKBURN **Telephone Number:** 847 251-1720
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2010 to 12/31/2010 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) MARK PICK
(Title) VICE PRESIDENT

Paid Preparer
(Signed) (Date)
(Print Name and Title) HAROLD D BLACKBURN, CPA
(Firm Name & Address) HAROLD D BLACKBURN INC. 1000 SKOKIE BLVD. WILMETTE, IL 60091
(Telephone) 847 251-1720 Fax # 847 251-4705

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

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	231	Skilled (SNF)	231	84,315	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	231	TOTALS	231	84,315	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			19,871	19,871	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	19,383	2,818		22,201	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,383	2,818	19,871	42,072	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 49.90%

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? TES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/1977

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 231 and days of care provided 12,791

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	428,216	22,645		450,861		450,861		450,861			1
2	Food Purchase		185,226		185,226		185,226	(592)	184,634			2
3	Housekeeping	372,202	56,635		428,837		428,837		428,837			3
4	Laundry	83,756	23,068		106,824		106,824		106,824			4
5	Heat and Other Utilities			295,055	295,055		295,055		295,055			5
6	Maintenance	94,806	108,948	41,540	245,294		245,294		245,294			6
7	Other (specify):*											7
8	**TOTAL General Services**	978,980	396,522	336,595	1,712,097		1,712,097	(592)	1,711,505			8
	B. Health Care and Programs											
9	Medical Director			116,950	116,950		116,950		116,950			9
10	Nursing and Medical Records	4,454,448	312,166	9,487	4,776,101		4,776,101		4,776,101			10
10a	Therapy	2,413,415	305,254	191,333	2,910,002		2,910,002		2,910,002			10a
11	Activities	172,577	1,263	5,263	179,103		179,103	(5,263)	173,840			11
12	Social Services	150,262			150,262		150,262		150,262			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	7,190,702	618,683	323,033	8,132,418		8,132,418	(5,263)	8,127,155			16
	C. General Administration											
17	Administrative	233,021		339,582	572,603		572,603	(83,197)	489,406			17
18	Directors Fees											18
19	Professional Services			247,091	247,091		247,091	9,325	256,416			19
20	Dues, Fees, Subscriptions & Promotions			112,186	112,186		112,186		112,186			20
21	Clerical & General Office Expenses	778,773	62,912	135,278	976,963		976,963	(1,223)	975,740			21
22	Employee Benefits & Payroll Taxes			1,603,774	1,603,774		1,603,774	15,243	1,619,017			22
23	Inservice Training & Education			67,479	67,479		67,479		67,479			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			158,800	158,800		158,800		158,800			26
27	Other (specify):*			12,599	12,599		12,599	(12,599)				27
28	**TOTAL General Administration**	1,011,794	62,912	2,676,789	3,751,495		3,751,495	(72,451)	3,679,044			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	9,181,476	1,078,117	3,336,417	13,596,010		13,596,010	(78,306)	13,517,704			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 BALLARD NURSING CENTER #0023093 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			48,000	48,000		48,000	316,017	364,017			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			142,732	142,732		142,732	593,757	736,489			32
33	Real Estate Taxes							377,156	377,156			33
34	Rent-Facility & Grounds			1,290,820	1,290,820		1,290,820	(1,290,820)				34
35	Rent-Equipment & Vehicles			25,755	25,755		25,755		25,755			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,507,307	1,507,307		1,507,307	(3,890)	1,503,417			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,275,659	143,493	1,419,152		1,419,152		1,419,152			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			126,473	126,473		126,473		126,473			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		1,275,659	269,966	1,545,625		1,545,625		1,545,625			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	9,181,476	2,353,776	5,113,690	16,648,942		16,648,942	(82,196)	16,566,746			45

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

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				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	(592)	2		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	(58,177)	17		18
19	Entertainment	(5,263)	11		19
20	Contributions				20
21	Owner or Key-Man Insurance	(1,716)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,599)	27		24
25	Fund Raising, Advertising and Promotional	(1,223)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (79,570)		$	30

BHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(2,626)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (2,626)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (82,196)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

BALLARD NURSING CENTER

ID# 0023093

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line 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 BALLARD NURSING CENTER **#** 0023093 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(592)	0	0	0	0	0	0	0	0	0	0	(592)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(592)	0	0	0	0	0	0	0	0	0	0	(592)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(5,263)	0	0	0	0	0	0	0	0	0	0	(5,263)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(5,263)	0	0	0	0	0	0	0	0	0	0	(5,263)	16
	C. General Administration													
17	Administrative	(58,177)	(25,020)	0	0	0	0	0	0	0	0	0	(83,197)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	9,325	0	0	0	0	0	0	0	0	0	9,325	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(1,223)	0	0	0	0	0	0	0	0	0	0	(1,223)	21
22	Employee Benefits & Payroll Taxes	(1,716)	16,959	0	0	0	0	0	0	0	0	0	15,243	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):*	(12,599)		0	0	0	0	0	0	0	0	0	(12,599)	27
28	**TOTAL General Administration**	(73,715)	1,264	0	0	0	0	0	0	0	0	0	(72,451)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(79,570)	1,264	0	0	0	0	0	0	0	0	0	(78,306)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BALLARD NURSING CENTER **#** 0023093 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	316,017	0	0	0	0	0	0	0	0	0	316,017	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	593,757	0	0	0	0	0	0	0	0	0	593,757	32
33	Real Estate Taxes	0	377,156	0	0	0	0	0	0	0	0	0	377,156	33
34	Rent-Facility & Grounds	0	(1,290,820)	0	0	0	0	0	0	0	0	0	(1,290,820)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	(3,890)	0	0	0	0	0	0	0	0	0	(3,890)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(79,570)	(2,626)	0	0	0	0	0	0	0	0	0	(82,196)	45

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ELI PICK	36.11	NONE		BALLARD PARTNERS LLC		BUILDING OWNEI
MOSHE PICK	38.89			PICK MANAGEMENT GROUP INC.		MGMT. CO.
HADASSAH PICK	22.22					
GLORIA PRUZAN	2.78					

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	$ 1,290,820	BALLARD PARTNERS LLC	100.00%	$	$ (1,290,820)	1
2	V								2
3	V	19	ACCOUNTING FEES				9,325	9,325	3
4	V	30	DEPRECIATION				316,017	316,017	4
5	V	32	INTEREST				593,757	593,757	5
6	V	33	REAL ESTATE TAXES				377,156	377,156	6
7	V								7
8	V	17	MANAGEMENT FEES	281,320	PICK MANAGEMENT GROUP	100.00%		(281,320)	8
9	V								9
10	V	17	SALARIES				256,300	256,300	10
11	V	27	PAYROLL TAXES				16,959	16,959	11
12	V								12
13	V								13
14	Total			$ 1,572,140			$ 1,569,514	$ * (2,626)	14

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

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MOSHE PICK	EXEC. DIR	ADMIN	38.89	NONE	40	100.00	SALARY	$ 128,150	17-7	1
2	ELI PICK	EXEC. DIR.	ADMIN	36.11	NONE	40	100.00	SALARY	128,150	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 256,300		13

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

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

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	M & T REALTY CAPITAL CORP		X	MORTGAGE	$97,136.00	09/25/2006	$ 9,592,200	$ 9,231,552	09-25-2041	5.8200	$ 593,757	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MB FINANCIAL		X	WORKING CAP& EQUIP.				2,412,521			142,732	6
7												7
8												8
9	TOTAL Facility Related				$97,136.00		$ 9,592,200	$ 11,644,073			$ 736,489	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 9,592,200	$ 11,644,073			$ 736,489	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #** _____

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

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

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 428,847	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.)		$ 393,154	2
3. Under or (over) accrual (line 2 minus line 1).		$ (35,659)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 412,815	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 377,156	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005	370,004	8
2006	357,020	9
2007	392,038	10
2008	408,387	11
2009	437,234	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BALLARD NURSING CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0023093

CONTACT PERSON REGARDING THIS REPORT HAROLD D. BLACKBURN CPA

TELEPHONE 847 251-1720 FAX #: 847 251-4705

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-15-303-013-0000	NURSING HOME	$ 393,154.00	$ 393,154.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 393,154.00	$ 393,154.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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 [X] (b) Rent equipment from a Related Organization. [X] (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 [X] NO
If so, please complete the following:

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

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	231		1991	1973	$ 2,851,196	$ 30,161	35	$ 90,514	$ 60,353	$ 1,820,379	4
5				1994	995,072	25,515	35	25,515		424,187	5
6				1994	986,459	25,294	35	25,294		407,866	6
7				1995	101,526	2,603	35	2,603		40,455	7
8											8
	Improvement Type**										
9	VARIOUS			1980	2,955		20			2,955	9
10	VARIOUS			1981	11,619		20			11,619	10
11	VARIOUS			1982	17,413		20			17,413	11
12	VARIOUS			1984	3,536		20			3,536	12
13	VARIOUS			1985	8,040		20			8,040	13
14	VARIOUS			1986	18,668		20			18,668	14
15	VARIOUS			1987	42,109	772	20		(772)	42,109	15
16	VARIOUS			1988	15,834	350	20		(350)	15,834	16
17	VARIOUS			1990	4,990	158	20	250	92	5,188	17
18	VARIOUS			1991	155,172	2,599	20	5,145	2,546	160,317	18
19	VARIOUS			1992	54,689	1,274	20	2,734	1,460	50,381	19
20	VARIOUS			1993	1,571	50	20	77	27	1,367	20
21	HEATING COOLING SYSTEM			1996	2,312	59	20	116	57	1,692	21
22	INTERIOR SIGNS			1996	350	9	20	18	9	262	22
23	BUILDING IMPROVEMENTS			1996	70,114	1,798	20	3,506	1,708	51,129	23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	AIR SYSTEM BALANCE	1996	$ 1,762	$ 297	20	$ 88	$ (209)	$ 1,283	37
38	MAV MOTOR REPLACEMENT	1996	2,000	51	20	100	49	1,458	38
39	INTERIOR SIGNS	1996	663	17	20	33	16	481	39
40	DRAPES	1996	616	16	20	31	15	452	40
41	COMP STATION CABLE	1996	2,566	66	20	128	62	1,867	41
42	HEATING AND COOLING SYSTEM	1997	2,999	77	20	150	73	2,000	42
43	SEWAGE PUMP	1997	2,498	64	20	125	61	1,708	43
44	CAULKING	1998	5,845	150	20	292	142	3,553	44
45	RENOVATION PATIOS	1998	6,134	157	20	307	150	3,838	45
46	A/C REPAIRS	1998	2,124	54	20	106	52	1,334	46
47	PARKING LOT	1998							47
48	ALARM SYSTEM	1998	2,500	64	20	125	61	1,615	48
49	SEWAGE PUMP	1998	2,498	64	20	125	61	1,625	49
50	A/C COUPLINGS	1998	2,905	74	20	145	71	1,837	50
51	PATIO FLOORS	1998	2,040	52	20	102	50	1,267	51
52	MOTOR	1998	1,544	40	20	77	37	988	52
53	SPRINKLER SYSTEM	1998	3,500	90	20	175	85	2,173	53
54	FAUCETS, COUPLINGS	1998	10,159	260	20	508	248	6,350	54
55	COMPRESSORS	1998	13,886	356	20	694	338	8,559	55
56	MEDICAL GAS PIPING	1999	124,600	3,195	20	6,230	3,035	73,203	56
57	ELECTRICAL WORK	1999	201,699	5,172	20	10,085	4,913	120,180	57
58	CHILLER REPLACEMENT	1999	76,355	1,958	20	3,818	1,860	44,543	58
59	AIR CARRIER	1999	693	18	20	35	17	388	59
60	CARPETING	1999	4,921	126	20	492	366	5,863	60
61	LOADING RAMP & PATIO	1999	127,175	3,261	20	6,359	3,098	74,718	61
62	SPRINKLER REPAIRS	1999	2,850	73	20	143	70	1,621	62
63	HEATING AND COOLING	1999	8,208	210	20	410	200	4,578	63
64	FLOW DEVICE OXYGEN	1999	1,760	45	20	88	43	1,027	64
65	ER GENER DESIGN	1999	11,614	298	20	568	270	6,816	65
66	DOOR CENSORS	1999	718	18	20	36	18	411	66
67	SIGNS	1999	18,235	468	20	912	444	10,640	67
68	METAL INCLOSURE	1999	934	24	20	47	23	517	68
69	PARKING AND AISLE PAVE	1999	65,443	1,678	20	3,272	1,594	37,975	69
70	TOTAL (lines 4 thru 69)		$ 6,055,069	$ 109,135		$ 191,578	$ 82,443	$ 3,508,265	70

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

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,055,069	$ 109,135		$ 191,578	$ 82,443	$ 3,508,265	1
2	NURSE CALL SYSTEM	1999	49,222	1,262	20	2,461	1,199	28,507	2
3	LOAD RAMP DESIGN	1999	14,368	368	20	718	350	8,437	3
4	DOOR LOCKS	1999	2,781	71	20	139	68	1,575	4
5	FIRE PANEL	1999	978	25	20	49	24	568	5
6	NURSE CALL SYSTEM	2000	49,221	1,262	20	2,461	1,199	26,661	6
7	KEYLESS ENTRY SYSTEM	2000	1,250	32	20	62	30	674	7
8	ELECTRICAL OUTLETS	2000	7,600	195	20	380	185	3,926	8
9	VENTILATION BOILER	2000	5,696	146	20	284	138	2,888	9
10	WEIL MCLAIN BOILER	2000	50,425	1,293	20	2,521	1,228	23,109	10
11	HOT WATER BOILER	2000	9,172	235	20	459	224	4,437	11
12									12
13	TELEPHONE SYSTEM	1999	83,381	2,138	20	4,169	2,031	76,432	13
14	TELEPHONE SYSTEM ENHANCEMENT	2000	1,716	44	10	168	124	1,884	14
15									15
16	PICK MGMT GROUP	1996	48,986	1,256	20		(1,256)	48,986	16
17									17
18	DIALYSIS SPACE/MEDICAL & GAS UPGRADES	2001	33,596	1,222	27.5	1,221	(1)	11,634	18
19	COOLING COIL REPLACEMENT	2001	24,604	894	27.5	895	1	8,540	19
20									20
21	BOILER	2002	49,501	1,800	20	2,475	675	21,038	21
22	VALVES/BOOSTER PUMP	2002	2,430	88	20	122	34	1,037	22
23	DIALYSIS ROOM	2002	89,870	3,268	20	4,494	1,226	38,199	23
24	REMOVE & REPAPER	2002	10,972	399	20	549	150	4,666	24
25	FLOORING/DRAPERIES	2002	27,204		20	1,360	1,360	12,788	25
26									26
27	ELEV CAB REPLACEMENT	2003	6,850	249	27.5	249		1,857	27
28	REPAIR FLUE / REMOVE & REPLACE GREASE TRAP	2003	12,463	453	27.5	453		3,379	28
29	BLINDS	2003	1,760	64	27.5	64		477	29
30	REPAIR AIR HANDLER/REPLACE DIGITAL THERMOSTAT	2003	5,690	207	27.5	207		1,544	30
31	DOORS	2003	1,387	51	27.5	51		380	31
32	SIDEWALK REPAIRS	2003	800	29	27.5	29		217	32
33	HOT WATER BOILER	2003	29,001	1,055	27.5	1,055		8,220	33
34	TOTAL (lines 1 thru 33)		$ 6,675,993	$ 127,241		$ 218,673	$ 91,432	$ 3,850,325	34

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

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 6,675,993	$ 127,241		$ 218,673	$ 91,432	$ 3,850,325	1
2	CARPET	2004	5,459	617	5	272	(345)	5,731	2
3	SEWER LINE REPLACEMENT	2004	2,385	87	27.5	87		562	3
4	FIRE SUPPRESSION SYSTEM	2004	2,579	94	27.5	94		607	4
5	ELEVATOR CAB REPLACEMENT	2004	6,850	249	27.5	249		1,608	5
6	REPLACE SEWER LINE	2004	20,625	750	27.5	750		3,750	6
7	CARPETING	2005	57,619		27.5	2,095	2,095	11,435	7
8	PLUMBING	2005	1,636		27.5	59	59	322	8
9	WINDOW TREATMENT	2005	1,783		27.5	65	65	355	9
10	OXYGEN SYSTEM/DINING ROOM REMODEL	2005	610,957		27.5	22,217	22,217	121,268	10
11	CARPETING	2006	2,063	75	27.5	75		334	11
12	WALLCOVERING	2006	40,424	1,470	27.5	1,470		6,554	12
13	INTERIOR DESIGN-CORRIDORS/DINING ROOM	2006	6,716	244	27.5	244		1,088	13
14	INSTALL 2 TANK UNITS	2006	18,520	673	27.5	673		3,000	14
15	WINDOW TREATMENT	2007	12,525	2,505	5	2,505		8,767	15
16	CARPETING DINING ROOMS	2007	60,529	5,918	5	12,106	6,188	42,371	16
17	PAINT/WALLPAPER/TILE	2007	14,965	2,993	5	2,993		10,476	17
18	CEILING TILE	2007	651	130	5	130		455	18
19	INTERIOR DESIGN-CORRIDORS/DINING ROOM	2007	375	75	5	75		262	19
20	INTERIOR DESIGN - HEART FAILURE UNIT	2007	5,206	1,041	5	1,041		3,644	20
21	PROCUREMENT SERVICES - CORRIDORS/DINING ROOM	2007	8,520	1,704	5	1,704		5,964	21
22	ROOFTOP AC UNIT	2007	5,552	1,111	5	1,111		3,888	22
23	CARPETING - RESIDENT ROOMS	2007	13,136	2,627	5	2,627		9,195	23
24	FRAMED ARTWORK - CORRIDORS/DINING ROOM	2007	3,370	674	5	674		2,359	24
25	INTERIOR DESIGN - HEART FAILURE UNIT	2008	2,205	37	27.5	80	43	197	25
26	INTERIOR DESIGN - CORRIDORS/DIING ROOM	2008	3,551	59	27.5	129	70	317	26
27	CARPETING, TECNO FLOORING & BASES - RESIDENT	2008	44,527	742	27.5	1,619	877	3,980	27
28	COUNTERTOP AND LIGHTS	2008	1,882	31	27.5	68	37	167	28
29	PAINT/WALLPAPER/MIRROR	2009	5,038	168	15	168		336	29
30	CARPET/TILE BEDROOMS, WASHROOMS & OFFICES	2009	5,198	174	15	174		348	30
31	PLUMBING REPAIRS	2009	3,556	118	15	118		236	31
32	VACUUM PUMP & EXHAUST FAN FOR PUMP	2009	73,725	3,072	27.5	3,072		6,144	32
33	INTERIOR DESIGN LOBBY'S UPPER & LOWER, LOUNGES	2009	32,157	1,340	27.5	1,340		2,680	33
34	TOTAL (lines 1 thru 33)		$ 7,750,277	$ 156,019		$ 278,757	$ 122,738	$ 4,108,725	34

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

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 7,750,277	$ 156,019		$ 278,757	$ 122,738	$ 4,108,725	1
2	FURNITURE FOR RESIDENT ROOMS	2009	70,612	2,942	27.5	2,942		5,884	2
3	INSULATION KITS FOR AROUND PIPES	2009	3,386	141	27.5	141		282	3
4	TV'S WITH MOUNTING BRACKETS	2009	11,923	497	27.5	497		994	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,836,198	$ 159,599		$ 282,337	$ 122,738	$ 4,115,885	34

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

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	$ 705,200	$ 31,440	$ 70,520	$ 39,080	10 YRS	$ 316,801	71
72	Current Year Purchases	49,192	2,208	2,460	252	10 YRS	2,460	72
73	Fully Depreciated Assets	323,157					323,157	73
74	RELATED PARTY	2,981,199	156,418	156,418				74
75	TOTALS	$ 4,058,748	$ 190,066	$ 229,398	$ 39,332		$ 642,418	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 11,894,946	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 349,665	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 511,735	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 162,070	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,758,303	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.

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

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.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ 292,061 Description: SEE ATTACHED LIST
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number BALLARD NURSING CENTER

STATE OF ILLINOIS
0023093 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 39,440	$		$ 39,440	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			20,389			20,389	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	39-2	# of prescrpts				900,492		900,492	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	RADILOOGY,LABS,RENTALS,OXYGEN Other (specify): MED SUPPLIES	39-2				37,835	420,996		458,831	13
14	TOTAL			$		$ 97,664	$ 1,321,488		$ 1,419,152	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.

STATE OF ILLINOIS

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2010 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 94,480	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 350,000)	6,821,630		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,810		6
7	Other Prepaid Expenses	128,689		7
8	Accounts Receivable (owners or related parties)	1,329,598		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 8,377,207	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	20,837		15
16	Equipment, at Historical Cost	1,056,712		16
17	Accumulated Depreciation (book methods)	(902,836)		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): CD & LEASE DEPOSIT	46,219		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 220,932	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,598,139	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,137,697	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,412,248		29
30	Accrued Salaries Payable	384,308		30
31	Accrued Taxes Payable (excluding real estate taxes)	777,727		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,711,980	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	743,102		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 743,102	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,455,082	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,143,057	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,598,139	$	48

***(See instructions.)**

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 707,109	1
2	Restatements (describe):		2
3	**POST CLOSING ADJUSTMENT**	128,954	3
4	**2010 CAPITAL CONTRIBUTIONS**	1,923,261	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,759,324	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(616,267)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (616,267)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,143,057	24 *

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

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 16,276,759	1
2	Discounts and Allowances for all Levels	(1,562,801)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 14,713,958	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,296,784	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,296,784	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	7,540	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 7,540	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	11,637	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 11,637	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscelaneous Income	2,756	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,756	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 16,032,675	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,712,097	31
32	Health Care	8,132,418	32
33	General Administration	3,751,495	33
	B. Capital Expense		
34	Ownership	1,507,307	34
	C. Ancillary Expense		
35	Special Cost Centers	1,419,152	35
36	Provider Participation Fee	126,473	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 16,648,942	40
41	**Income before Income Taxes (line 30 minus line 40)****	(616,267)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (616,267)	43

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

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

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

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

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,656	1,656	$ 86,748	$ 52.38	1
2	Assistant Director of Nursing	2,496	2,496	136,135	54.54	2
3	Registered Nurses	52,481	54,523	1,961,022	35.97	3
4	Licensed Practical Nurses	13,860	14,610	396,009	27.11	4
5	CNAs & Orderlies	108,882	114,798	1,837,371	16.01	5
6	CNA Trainees					6
7	Licensed Therapist	24,058	25,434	880,363	34.61	7
8	Rehab/Therapy Aides	51,097	53,301	1,492,452	28.00	8
9	Activity Director	3,488	3,488	64,417	18.47	9
10	Activity Assistants	8,679	9,408	108,160	11.50	10
11	Social Service Workers	7,606	7,893	150,262	19.04	11
12	Dietician					12
13	Food Service Supervisor	1,964	1,964	55,570	28.29	13
14	Head Cook					14
15	Cook Helpers/Assistants	32,490	33,730	372,646	11.05	15
16	Dishwashers					16
17	Maintenance Workers	6,322	6,536	94,806	14.51	17
18	Housekeepers	35,897	37,786	372,202	9.85	18
19	Laundry	5,657	5,856	83,756	14.30	19
20	Administrator	2,000	2,000	151,207	75.60	20
21	Assistant Administrator	2,064	2,064	81,814	39.64	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	30,530	31,620	778,773	24.63	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,928	1,960	37,163	18.96	31
32	Other Health Care(specify)			40,600		32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	393,155	411,123	$ 9,181,476 *	$ 22.33	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 8,686	10-3	35
36	Medical Director	O	116,950	9-3	36
37	Medical Records Consultant	N	2,576	10-3	37
38	Nurse Consultant	T			38
39	Pharmacist Consultant	H	23,610	10-3	39
40	Physical Therapy Consultant	L			40
41	Occupational Therapy Consultant	Y	39,440	10-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	F	20,389	10-3	43
44	Activity Consultant	E	1,233	10-3	44
45	Social Service Consultant	E			45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 212,884		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
SUSAN AHLGREN	ADMINISTRATOR		$ 151,207
RICK HENNESSY	ASST ADMIN		81,814
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 233,021

B. Administrative - Other

Description	Amount
MANAGEMENT FEE	$ 281,320
NON ALLOWABLE COSTS	8,100
PENALTIES	50,077
TOTAL (agree to Schedule V, line 17, col. 3)	$ 339,497
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE ATTACHED SCHEDULE		247,091
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 247,091

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 118,178
Unemployment Compensation Insurance	25,946
FICA Taxes	679,429
Employee Health Insurance	765,972
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS-OTHER	12,533
INSURANCE-EXECUTIVE LIFE	1,716
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,603,774

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
DUES,MEMBERSHIPS,SUBSCRIPTIONS	28,104
PUBLIC RELATIONS	74,266
TAXES & LICENSES	9,816
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 112,186

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

**See instructions.

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ICLTC $21,483**

(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? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **8,662** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **126,473**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **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. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.