FOR BHF USE

LL1

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.

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

I. IDPH License ID Number: 8000796

Facility Name: Hamilton Memorial Nursing Center

Address: 611 South Marshall Avenue (Number) McLeansboro (City) 62859 (Zip Code)

County: Hamilton

Telephone Number: (618) 643-2361 **Fax #** (618) 643-2875

HFS ID Number:

Date of Initial License for Current Owners: 1970

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Karla Heil **Telephone Number:** (618) 643-2361
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 7/1/09 to 6/30/10 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) Randall Dauby
(Title) Administrator

Paid Preparer

(Signed) (Date)
(Print Name and Title) David Schnake, Partner
(Firm Name & Address) Kerber, Eck & Braeckel LLP, 1116 W. Main Street, Carbondale, IL 62901
(Telephone) (618) 529-1040 Fax # (618) 549-2311

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 Hamilton Memorial Nursing Center # 8000796 Report Period Beginning: 7/1/09 Ending: 6/30/10

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 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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	60	Intermediate (ICF)	60	21,900	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	60	TOTALS	60	21,900	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					8
9	SNF/PED					9
10	ICF	12,110	4,055		16,165	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,110	4,055		16,165	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.81%

D. How many bed-hold days during this year were paid by the Department?
122 (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 [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 1970

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 [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

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

Is your fiscal year identical to your tax year? YES [ ] NO [N/A]

Tax Year: _____ Fiscal Year: _____

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

Facility Name & ID Number Hamilton Memorial Nursing Center # 8000796 Report Period Beginning: 7/1/09 Ending: 6/30/10

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	211,236	25,702	974	237,912		237,912		237,912			1
2	Food Purchase		74,039		74,039		74,039	(1,035)	73,004			2
3	Housekeeping	71,731	11,097		82,828		82,828		82,828			3
4	Laundry		119,924		119,924		119,924	38,358	158,282			4
5	Heat and Other Utilities			88,472	88,472		88,472		88,472			5
6	Maintenance	21,254	901	12,461	34,616		34,616		34,616			6
7	Other (specify):*											7
8	TOTAL General Services	304,221	231,663	101,907	637,791		637,791	37,323	675,114			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	821,341	23,004	4,317	848,662		848,662	(184)	848,478			10
10a	Therapy											10a
11	Activities	32,634	4,130	605	37,369		37,369		37,369			11
12	Social Services	23,899	18	2,160	26,077		26,077		26,077			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	877,874	27,152	7,082	912,108		912,108	(184)	911,924			16
	C. General Administration											
17	Administrative	77,109	1,969	8,062	87,140	(489)	86,651	178,039	264,690			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions											20
21	Clerical & General Office Expenses					489	489	7,119	7,608			21
22	Employee Benefits & Payroll Taxes			303,389	303,389		303,389	15,728	319,117			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			19,763	19,763		19,763		19,763			26
27	Other (specify):*											27
28	TOTAL General Administration	77,109	1,969	331,214	410,292		410,292	200,886	611,178			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,259,204	260,784	440,203	1,960,191		1,960,191	238,025	2,198,216			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 Center #8000796 **Report Period Beginning:** 7/1/09 **Ending:** 6/30/10

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			105,074	105,074		105,074		105,074			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			60,469	60,469		60,469	(1,832)	58,637			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			165,543	165,543		165,543	(1,832)	163,711			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			4,613	4,613		4,613		4,613			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee							32,850	32,850			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			4,613	4,613		4,613	32,850	37,463			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,259,204	260,784	610,359	2,130,347		2,130,347	269,043	2,399,390			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 Hamilton Memorial Nursing Center # 8000796 Report Period Beginning: 7/1/09 Ending: 6/30/10

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	(1,035)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,544)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(184)	10		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,832)	32		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				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				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 **Provider Tax**	32,850	42		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 28,255		$	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)	240,788		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 240,788		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 269,043		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.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Hamilton Memorial Nursing Center

ID# 8000796

Report Period Beginning: 7/1/09

Ending: 6/30/10

	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 Hamilton Memorial Nursing Center **#** 8000796 **Report Period Beginning:** 7/1/09 **Ending:** 6/30/10

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	(1,035)	0	0	0	0	0	0	0	0	0	0	(1,035)	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**	(1,035)	0	0	0	0	0	0	0	0	0	0	(1,035)	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	(184)	0	0	0	0	0	0	0	0	0	0	(184)	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	**TOTAL Health Care and Programs**	(184)	0	0	0	0	0	0	0	0	0	0	(184)	16
	C. General Administration													
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	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(1,544)	0	0	0	0	0	0	0	0	0	0	(1,544)	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	**TOTAL General Administration**	(1,544)	0	0	0	0	0	0	0	0	0	0	(1,544)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(2,763)	0	0	0	0	0	0	0	0	0	0	(2,763)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Hamilton Memorial Nursing Center # 8000796 **Report Period Beginning:** 7/1/09 **Ending:** 6/30/10

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,832)	0	0	0	0	0	0	0	0	0	0	(1,832)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	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**	(1,832)	0	0	0	0	0	0	0	0	0	0	(1,832)	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)**	(4,595)	0	0	0	0	0	0	0	0	0	0	(4,595)	45

Facility Name & ID Number Hamilton Memorial Nursing Center # 8000796 Report Period Beginning: 7/1/09 Ending: 6/30/10

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
Hamilton Memorial Hospital District	100%			Hamilton Memorial H	McLeansboro	Hospital
				Hamilton Memorial H	McLeansboro	Home Health Agenc

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				$	Hamilton Memorial Hospital District	N/A	$	$	1
2	V					Hamilton Memorial Hospital HHA	N/A			2
3	V									3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$			$	$ *	14

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

Facility Name & ID Number Hamilton Memorial Nursing Center # 8000796 Report Period Beginning: 7/1/09 Ending: 6/30/10

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

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

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

Facility Name & ID Number Hamilton Memorial Nursing Center # 8000796 Report Period Beginning: 7/1/09 Ending: 6/30/10

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 [X] NO [ ]

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

Name of Related Organization: Hamilton Memorial Hospital
Street Address: 611 S. Marshall P.O. Box 429
City / State / Zip Code: McLeansboro, IL 62859
Phone Number: ((618) 643-2361
Fax Number: ((618) 643-2875

	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	4	Laundry	Pounds of Laundry			$	$		$ 38,358	1
2	17	Administration	Accumulated Costs						178,039	2
3	21	Phone Expense	Number of Phones						3,061	3
4	21	Purchases	Supply Costs						5,602	4
5	22	Employee Benefits	Gross Salaries						15,728	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					$	$		$ 240,788	25

Facility Name & ID Number Hamilton Memorial Nursing Center # 8000796 Report Period Beginning: 7/1/09 Ending: 6/30/10

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	Hospital Revenue Bonds		X	Building Construction	Variable	11/1/2007	$ 18,500,000	$ 18,225,000	11/21/2037	Variable	$ 60,469	1
2	(THE ABOVE IS TOTAL LOAN FOR HOSPITAL AND NURSING HOME, ONLY INTEREST COST RELATED TO NURSING HOME IS LISTED ON SCHEDULE V. PAGE 4.)											2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 18,500,000	$ 18,225,000			$ 60,469	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 18,500,000	$ 18,225,000			$ 60,469	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 19,763 **Line #** 26

*** 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 Hamilton Memorial Nursing Center **#** 8000796 **Report Period Beginning:** 7/1/09 **Ending:** 6/30/10

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.**	$	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 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$	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.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2005	8
	2006	9
	2007	10
	2008	11
	2009	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 Hamilton Memorial Nursing Center COUNTY Hamilton

FACILITY IDPH LICENSE NUMBER 8000796

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE ( ) _____ FAX #: ( ) _____

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.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

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 _____ 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 Hamilton Memorial Nursing Center # 8000796 Report Period Beginning: 7/1/09 Ending: 6/30/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 16,358 B. General Construction Type: Exterior Brick Frame Number of Stories 1

C. Does the Operating Entity? [X] (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? [X] (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).

Hamilton Memorial Hospital District
Hospital
77,614 Sq. Feet
25 Beds

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		17,402	1959	$ 4,690	1
2					2
3	TOTALS	17,402		$ 4,690	3

Facility Name & ID Number Hamilton Memorial Nursing Center # 8000796 Report Period Beginning: 7/1/09 Ending: 6/30/10

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	60		1970	1970	$ 258,985	$ 5,388	40	$ 5,388	$	$ 258,685	4
5			1970	1970	94,949		20			94,949	5
6											6
7											7
8											8
	Improvement Type**										
9				1970	6,888		20			6,888	9
10				1971	2,554		15			2,554	10
11				1974	72		20			72	11
12				1975	764		20			764	12
13				1977	10,178		10			10,178	13
14				1983	2,798		20			2,798	14
15				1984	2,312		15			2,312	15
16				1989	3,216		10			3,216	16
17				1990	2,231		5			2,231	17
18				1991	2,400		15			2,400	18
19				1991	1,166		10			1,166	19
20				1991	2,892		5			2,892	20
21				1991	13,242		10			13,242	21
22				1991	7,500		5			7,500	22
23				1992	384		5			384	23
24				1992	1,317		10			1,317	24
25				1993	1,466		5			1,466	25
26				1996	1,920		5			1,920	26
27				1996	960	64	15	64		928	27
28				1997	3,506		10			3,506	28
29				1997	3,491	233	15	233		3,143	29
30				1998	1,085		5			1,085	30
31				1998	2,385		10			2,385	31
32				1998	1,206		10			1,206	32
33				1998	2,471		10			2,471	33
34				1999	35,462	2,364	15	2,364		27,187	34
35				1999	1,986		8			1,986	35
36				1999	961		5			961	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 Hamilton Memorial Nursing Center # 8000796 Report Period Beginning: 7/1/09 Ending: 6/30/10

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		1999	$ 747	$	10	$	$	$ 747	37
38	BREAKER PANEL	1999	600		10			600	38
39	A/C UNIT	1999	1,917		5			1,917	39
40	HOT TAR FOR ACTIVITY ROOM ROOF	1999	500		5			500	40
41	ACTIVITY ROOM WINDOW	1999	4,706	314	15	314		3,296	41
42	DYNALINE HEAT/AIR WALL UNITS	2000	11,161	744	15	744		7,068	42
43	FURNANCE/DUCT WORK-DINIG	2000	1,111	74	15	74		703	43
44	ROOF REPAIRS - SUNROOM DINING ROOM	2001	15,100	1,510	10	1,510		12,835	44
45	ROOF REPAIRS- WALKWAY TO HOSPITAL	2002	5,450	545	10	545		4,633	45
46	ROOF REPAIRS - HALL DAMAGE	2002	3,188	319	10	319		2,391	46
47	A/C UNIT	2002	749	75	10	75		562	47
48	GUTTER/DOWNSPOUTS&INSTALLATION	2002	2,481	248	10	248		1,860	48
49	DYNALINE HEAT/AIR WALL UNITS(10)	2002	17,218	1,148	15	1,148		8,610	49
50	DYNALINE HEAT/AIR WALL UNITS(5)	2003	8,809	587	15	587		4,403	50
51	FRONT PORCH SIDING REPAIRS	2004	1,943	194	10	194		1,262	51
52	DOOR REPLACEMENT W/ FIREPROOF DOOR	2004	1,220	122	10	122		793	52
53	GREASE TRAP INSTALLATION	2004	6,172	309	20	309		2,008	53
54	HOT WATER HEATER- HIGH EFFICIENY	2004	5,600	560	10	560		3,640	54
55	RENOVATIONS- DINING ROOM/OTHER	2004	22,802	2,280	10	2,280		14,821	55
56	ROLLING STEEL FIRE SHUTTER- DINING ROOM	2004	1,798	180	10	180		1,169	56
57	CONCREATE/RAMP SIDEWALK	2004	5,210	347	15	347		1,910	57
58	TILR/WALLPAPER/PAINT	2004	21,882	1,459	15	1,459		8,024	58
59	FIRE ALAM SYSTEM UPGRADE	2004	5,503	550	10	550		3,025	59
60	PAINTING OF RESIDENT ROOMS	2005	30,813	2,008	15	2,008		11,044	60
61	DIESEL GENERATOR	2005	7,400	370	20	370		2,035	61
62	PAINTING OF CLOSET DOORS- RESIDENT ROOMS	2006	3,000	200	15	200		900	62
63	HALLWAYS PAINTINGS, LIGHTNIG, RAILS	2006	41,167	2,744	15	2,744		12,349	63
64	SPINLKER SYSTEM REPLACEMENT	2006	69,900	2,796	25	2,796		12,582	64
65	HALLWAY TILE INSTALLATION	2006	6,580	439	15	439		1,975	65
66	GENERATOR MONITOR, ANNUNCIATOR	2006	3,233	162	20	162		728	66
67	HOT WATER BOOSTER HEAT-COMPACT	2008	1,181	118	10	118		531	67
68	HANDRAIL INSTALLATION	2006	2,500	167	15	167		751	68
69	HOT WATER HEATER- 92 GALLON	2008	4,990	499	10	499		1,248	69
70	TOTAL (lines 4 thru 69)		$ 787,378	$ 29,117		$ 29,117	$	$ 592,712	70

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

Facility Name & ID Number Hamilton Memorial Nursing Center # 8000796 Report Period Beginning: 7/1/09 Ending: 6/30/10

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		$ 787,378	$ 29,117		$ 29,117	$	$ 592,712	1
2	WINDOW REPLACEMENT(40)	2009	16,070	1,071	15	1,071		1,607	2
3	KITCHEN BUILDING ADDITION	2009	731,418	36,571	20	36,571		54,856	3
4	NEW CONSTRUCTION	2009	1,520	38	20	38		38	4
5	DRAIN TILE, SIDEWALK-SOUTH SIDE	2009	6,038	201	15	201		201	5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,542,424	$ 66,998		$ 66,998	$	$ 649,414	34

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

Facility Name & ID Number Hamilton Memorial Nursing Center # 8000796 Report Period Beginning: 7/1/09 Ending: 6/30/10

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	$ 593,552	$ 38,076	$ 38,076	$		$ 318,152	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 593,552	$ 38,076	$ 38,076	$		$ 318,152	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)	$ 2,140,666	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 105,074	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 105,074	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)	$ 967,566	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 Hamilton Memorial Nursing Center # 8000796 Report Period Beginning: 7/1/09 Ending: 6/30/10

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

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

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: ____ *

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	$

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

* 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 Hamilton Memorial Nursing Center # 8000796 Report Period Beginning: 7/1/09 Ending: 6/30/10

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 Hamilton Memorial Nursing Center # 8000796 Report Period Beginning: 7/1/09 Ending: 6/30/10

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		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							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	TOTAL			$		$	$		$	14

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

STATE OF ILLINOIS

Facility Name & ID Number Hamilton Memorial Nursing Center # 8000796 Report Period Beginning: 7/1/09 Ending: 6/30/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/10 (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	$ 10,797	$ 1,838,263	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)		2,255,806	3
4	Supply Inventory (priced at)	13,879	395,805	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses		272,889	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Third Party Reimb		273,036	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 24,676	$ 5,035,799	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	4,690	74,449	13
14	Buildings, at Historical Cost	1,542,424	20,767,229	14
15	Leasehold Improvements, at Historical Cost		591,372	15
16	Equipment, at Historical Cost	593,552	5,639,144	16
17	Accumulated Depreciation (book methods)	(967,566)	(9,282,895)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		1,843,196	21
22	Other Long-Term Assets (spe CIP		1,257,160	22
23	Other(specify): Unamortized Bond Cost		573,453	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,173,100	$ 21,463,108	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,197,776	$ 26,498,907	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$ 455,711	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		433,056	29
30	Accrued Salaries Payable		497,588	30
31	Accrued Taxes Payable (excluding real estate taxes)			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	Est Third Party Liability		177,418	36
37	Other		152,759	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$	$ 1,716,532	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		17,935,000	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Interest Rate Swap Contract		3,175,000	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 21,110,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$	$ 22,826,532	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,197,776	$ 3,672,375	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,197,776	$ 26,498,907	48

*(See instructions.)

Facility Name & ID Number Hamilton Memorial Nursing Center # 8000796 Report Period Beginning: 7/1/09 Ending: 6/30/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,294,299	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,294,299	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(450,755)	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)	354,232	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (96,523)	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)**	$ 1,197,776	24 *

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

Facility Name & ID Number Hamilton Memorial Nursing Center # 8000796 Report Period Beginning: 7/1/09 Ending: 6/30/10

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	$ 1,541,131	1
2	Discounts and Allowances for all Levels	(31,068)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,510,063	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	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	5,129	13
14	Non-Patient Meals	1,035	14
15	Telephone, Television and Radio	1,544	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	184	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)**	$ 7,892	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,832	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,832	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Tax Revenue	159,805	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 159,805	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,679,592	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	637,791	31
32	Health Care	912,108	32
33	General Administration	410,292	33
	B. Capital Expense		
34	Ownership	165,543	34
	C. Ancillary Expense		
35	Special Cost Centers	4,613	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,130,347	40
41	**Income before Income Taxes (line 30 minus line 40)****	(450,755)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (450,755)	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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 Center # 8000796 Report Period Beginning: 7/1/09 Ending: 6/30/10

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	2,520	2,866	$ 77,399	$ 27.01	1
2	Assistant Director of Nursing					2
3	Registered Nurses	769	779	14,284	18.34	3
4	Licensed Practical Nurses	17,015	19,933	308,126	15.46	4
5	CNAs & Orderlies	38,380	43,271	421,531	9.74	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,950	3,403	32,635	9.59	10
11	Social Service Workers	1,864	1,952	23,899	12.24	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,906	22,155	211,236	9.53	15
16	Dishwashers					16
17	Maintenance Workers	1,861	2,072	21,254	10.26	17
18	Housekeepers	6,965	7,866	71,731	9.12	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	3,656	3,977	77,109	19.39	23
24	Clerical					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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	95,886	108,274	$ 1,259,204 *	$ 11.63	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		$		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 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 Hamilton Memorial Nursing Center # 8000796 Report Period Beginning: 7/1/09 Ending: 6/30/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Karla Heil	NC Administrator		$ 77,109
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 77,109

B. Administrative - Other

Description	Amount
Audit Fees	$ 3,617
Travel	1,283
Postage (173), Bad Debt (2,573)	2,746
Dues (100), Equipment Rental (316)	416
TOTAL (agree to Schedule V, line 17, col. 3)	$ 8,062
(Attach a copy of any management service agreement)	

C. Professional Services

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

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 26,344
Unemployment Compensation Insurance	12,247
FICA Taxes	88,044
Employee Health Insurance	120,000
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	52,557
Other	4,197
Expense on Medicare Cost Report	15,728
TOTAL (agree to Schedule V, line 22, col.8)	$ 319,117

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	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$

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 Hamilton Memorial Nursing Center # 8000796 Report Period Beginning: 7/1/09 Ending: 6/30/10

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 Hamilton Memorial Nursing Center # 8000796 Report Period Beginning: 7/1/09 Ending: 6/30/10

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES except RN**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line **N/A**

(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. $ **32,850**
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. $ **N/A** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **Kerber, Eck & Braeckel LLP**

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

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