FOR BHF USE

LL1

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: 8049116

Facility Name: Harvard Memorial Hospital

Address: 901 South Grant, P.O. Box 850 (Number) Harvard (City) 60033 (Zip Code)

County: McHenry

Telephone Number: (608)755-5362 **Fax #** (608)741-7368

HFS ID Number:

Date of Initial License for Current Owners: 1954

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Tammy Jones **Telephone Number:** (608)755-5362x5012
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 7/1/2009 to 6/30/2010 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) Scott Moebius
(Title) Corporate Controller

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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 Harvard Memorial Hospital # 8049116 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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 _____

	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	45	Skilled (SNF)	45	16,425	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	45	TOTALS	45	16,425	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,032	3,915	3,529	9,476	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	2,032	3,915	3,529	9,476	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 57.69%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 1976

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

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 14 and days of care provided 3,228

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: 6/30/10 Fiscal Year: 6/30/10

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

Facility Name & ID Number Harvard Memorial Hospital # 8049116 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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	402,196	27,617	152,332	582,145	(2,094)	580,051	(82,624)	497,427			1
2	Food Purchase											2
3	Housekeeping	217,731	20,816	33,066	271,613	(200)	271,413	(228,030)	43,383			3
4	Laundry		908	1,266	2,174		2,174	(1,246)	928			4
5	Heat and Other Utilities					272,323	272,323	(228,794)	43,529			5
6	Maintenance		400	848,442	848,842	(329,833)	519,009	(436,049)	82,960			6
7	Other (specify):* (Purchasing/CS)	64,091	756	2,361	67,208	(208)	67,000	(9,544)	57,456			7
8	**TOTAL General Services**	684,018	50,497	1,037,467	1,771,982	(60,012)	1,711,970	(986,287)	725,683			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	5,348,506	2,144,100	2,292,034	9,784,640	(6,722,772)	3,061,868	(178,508)	2,883,360			10
10a	Therapy	795,745	19,886	42,065	857,696	(21,464)	836,232	(119,116)	717,116			10a
11	Activities											11
12	Social Services											12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Rad,Lab,Pharmacy	1,331,647	203,919	1,018,734	2,554,300	(2,554,300)						15
16	**TOTAL Health Care and Programs**	7,475,898	2,367,905	3,352,833	13,196,636	(9,298,536)	3,898,100	(297,624)	3,600,476			16
	C. General Administration											
17	Administrative	49,866	1,669	239,833	291,368	(61,181)	230,187	(110,634)	119,553			17
18	Directors Fees											18
19	Professional Services					13,215	13,215	(6,493)	6,722			19
20	Dues, Fees, Subscriptions & Promotions					58,428	58,428	(28,706)	29,722			20
21	Clerical & General Office Expenses	298,020	4,417	532,545	834,982	(2,815)	832,167	(408,844)	423,323			21
22	Employee Benefits & Payroll Taxes			2,083,006	2,083,006	(304,459)	1,778,547	(1,464,155)	314,392			22
23	Inservice Training & Education											23
24	Travel and Seminar					32,684	32,684	(16,058)	16,626			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			61,800	61,800		61,800	(30,362)	31,438			26
27	Other (specify):* Market,HR,Volun	8,130	1,317	662,877	672,324	(7,139)	665,185	(547,601)	117,584			27
28	**TOTAL General Administration**	356,016	7,403	3,580,061	3,943,480	(271,267)	3,672,213	(2,612,853)	1,059,360			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	8,515,932	2,425,805	7,970,361	18,912,098	(9,629,815)	9,282,283	(3,896,764)	5,385,519			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 Harvard Memorial Hospital #8049116 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			1,301,771	1,301,771		1,301,771	(1,276,670)	25,101			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			901,723	901,723	77	901,800	(901,800)				32
33	Real Estate Taxes					55,240	55,240	(55,240)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles					47,318	47,318	(22,318)	25,000			35
36	Other (specify):* **Bad Debt**			1,887,462	1,887,462		1,887,462	(1,887,462)				36
37	**TOTAL Ownership**			4,090,956	4,090,956	102,635	4,193,591	(4,143,490)	50,101			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					9,502,542	9,502,542	(9,502,542)				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					24,638	24,638		24,638			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**					9,527,180	9,527,180	(9,502,542)	24,638			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	8,515,932	2,425,805	12,061,317	23,003,054		23,003,054	(17,542,796)	5,460,258			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 Harvard Memorial Hospital # 8049116 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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				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 Harv Econ Dev Dues	5,000			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 5,000		$	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)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 5,000		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		see schedule	15	42
43	Prescription Drugs		x			43
44						44
45	Other-Attach Schedule	x		see schedule	10,15,22	45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Harvard Memorial Hospital

ID# 8049116

Report Period Beginning: 7/1/2009

Ending: 6/30/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Dietary Expense not related to SNF Care	$ (82,624)	1	1
2	Housekeeping Expenses not related to SNF Care	(228,030)	3	2
3	Laundry Expenses not related to SNF Care	(1,246)	4	3
4	Heat & Other Utilites not related to SNF Care	(228,794)	5	4
5	Maintenance Expenses not related to SNF Care	(436,049)	6	5
6	Central Supply Expense not related to SNF Care	(9,544)	7	6
7	Nursing & Medical Records Exp not related to SNF	(178,508)	10	7
8	Therapy Expenses not related to SNF Care	(119,116)	10a	8
9	Administrative Expenses not related to SNF Care	(110,634)	17	9
10	Professional Services not related to SNF Care	(6,493)	19	10
11	Dues, Fees & Subscriptions not related to SNF Care	(28,706)	20	11
12	Clerical & General Office Exp not related to SNF	(408,844)	21	12
13	Employee Ben & Payroll Taxes not related to SNF	(1,464,155)	22	13
14	Travel & Seminar Expense not related to SNF	(16,058)	24	14
15	Insurance Expenses not related to SNF Care	(30,362)	26	15
16	Human Res & Marketing Exp not related to SNF	(547,601)	27	16
17	Depreciation Expense not related to SNF Care	(1,276,670)	30	17
18	Interest Expense not related to SNF Care	(901,800)	32	18
19	Real Estate Taxes not related to SNF Care	(55,240)	33	19
20	Rent Expense-Equipment not related to SNF Care	(22,318)	35	20
21	Ancillary Services related to Acute - not SNF Oper	(9,502,542)	39	21
22	Bad Debt Expense	(1,887,462)	36	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**	(17,542,796)		49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Harvard Memorial Hospital **#** 8049116 **Report Period Beginning:** 7/1/2009 **Ending:** 6/30/2010

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	(82,624)	0	0	0	0	0	0	0	0	0	0	(82,624)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	(228,030)	0	0	0	0	0	0	0	0	0	0	(228,030)	3
4	Laundry	(1,246)	0	0	0	0	0	0	0	0	0	0	(1,246)	4
5	Heat and Other Utilities	(228,794)	0	0	0	0	0	0	0	0	0	0	(228,794)	5
6	Maintenance	(436,049)	0	0	0	0	0	0	0	0	0	0	(436,049)	6
7	Other (specify):*	(9,544)	0	0	0	0	0	0	0	0	0	0	(9,544)	7
8	**TOTAL General Services**	(986,287)	0	0	0	0	0	0	0	0	0	0	(986,287)	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	(178,508)	0	0	0	0	0	0	0	0	0	0	(178,508)	10
10a	Therapy	(119,116)	0	0	0	0	0	0	0	0	0	0	(119,116)	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**	(297,624)	0	0	0	0	0	0	0	0	0	0	(297,624)	16
	C. General Administration													
17	Administrative	(110,634)	0	0	0	0	0	0	0	0	0	0	(110,634)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(6,493)	0	0	0	0	0	0	0	0	0	0	(6,493)	19
20	Fees, Subscriptions & Promotions	(28,706)	0	0	0	0	0	0	0	0	0	0	(28,706)	20
21	Clerical & General Office Expenses	(408,844)	0	0	0	0	0	0	0	0	0	0	(408,844)	21
22	Employee Benefits & Payroll Taxes	(1,464,155)	0	0	0	0	0	0	0	0	0	0	(1,464,155)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(16,058)	0	0	0	0	0	0	0	0	0	0	(16,058)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(30,362)	0	0	0	0	0	0	0	0	0	0	(30,362)	26
27	Other (specify):*	(547,601)	0	0	0	0	0	0	0	0	0	0	(547,601)	27
28	**TOTAL General Administration**	(2,612,853)	0	0	0	0	0	0	0	0	0	0	(2,612,853)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(3,896,764)	0	0	0	0	0	0	0	0	0	0	(3,896,764)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Harvard Memorial Hospital # 8049116 **Report Period Beginning:** 7/1/2009 **Ending:** 6/30/2010

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	(1,276,670)	0	0	0	0	0	0	0	0	0	0	(1,276,670)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(901,800)	0	0	0	0	0	0	0	0	0	0	(901,800)	32
33	Real Estate Taxes	(55,240)	0	0	0	0	0	0	0	0	0	0	(55,240)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	(22,318)	0	0	0	0	0	0	0	0	0	0	(22,318)	35
36	Other (specify):*	(1,887,462)	0	0	0	0	0	0	0	0	0	0	(1,887,462)	36
37	TOTAL Ownership	(4,143,490)	0	0	0	0	0	0	0	0	0	0	(4,143,490)	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	(9,502,542)	0	0	0	0	0	0	0	0	0	0	(9,502,542)	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	(9,502,542)	0	0	0	0	0	0	0	0	0	0	(9,502,542)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(17,542,796)	0	0	0	0	0	0	0	0	0	0	(17,542,796)	45

Facility Name & ID Number Harvard Memorial Hospital # 8049116 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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
Mercy Health System	100			Mercy Hospital	Janesville	Hospital
				Mercy Assisted Care	Janesville	Includes Homecare
				Mercy Alliance	Janesville	Parent Corporation
				Mercy Walworth Hosp	Lake Geneva	Hospital

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

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

1 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			$			$	$	1
2	V				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 Harvard Memorial Hospital # 8049116 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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

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

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

Facility Name & ID Number Harvard Memorial Hospital # 8049116 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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 [x] NO [ ]

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

Name of Related Organization: Mercy Health System
Street Address: 1000 Mineral Point Aveneu
City / State / Zip Code: Janesville, WI 53546
Phone Number: ((608)755-5362x5012
Fax Number: ((608)741-7368

	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	6	Maintenance	Hours Worked	50,873	3	$ 1,215,796	$ 1,215,796	8,839	$ 211,250	1
2	27	Marketing	Hours Worked	42,928	5	1,040,675	1,040,675	3,029	73,438	2
3	21	Information Systems	Hours Worked	137,137	4	4,092,873	4,092,873	2,555	76,250	3
4	21	Finance	Hours Worked	51,139	6	1,424,760	1,424,760	4,576	127,500	4
5	27	Human Resources	Hours Worked	40,491	4	1,013,850	1,013,850	5,387	134,875	5
6	21	Business Office	Hours Worked	167,626	2	2,407,151	2,407,151	12,935	185,750	6
7	17	Executive Salaries	Hours Worked	42,724	4	4,142,825	4,142,825	967	93,750	7
8	22	Pension Expense	Actual Expense	1	1	286,203	0	1	286,203	8
9	22	Worker's Compensation	FTEs	3,233	5	1,748,414	60,005	111	60,005	9
10	26	Gen/Prof Liability Exp	Actual Expense	1	1	61,800	0	1	61,800	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 17,434,347	$ 15,397,935		$ 1,310,821	25

Facility Name & ID Number Harvard Memorial Hospital # 8049116 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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	1998 Bond Issue	x		Medical Clinic Construction	$75,000 annual	1998	$ 1,750,000	$			$	1
2	Mercy Alliance Loan	x		Hospital Renovations	varies	2003	5,570,000	9,001,408			496,323	2
3	Interentity Bond Payable 2005	x		Intercompany LT Payable	varies	2005	3,901,107	6,935,805			332,809	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 11,221,107	$ 15,937,213			$ 829,132	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 11,221,107	$ 15,937,213			$ 829,132	15

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

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

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

Facility Name & ID Number Harvard Memorial Hospital # 8049116 **Report Period Beginning:** 7/1/2009 **Ending:** 6/30/2010

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.**	$	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

N/A Hospital Property is classified as Not For Profit - Tax Exempt

	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 Harvard Memorial Hospital COUNTY McHenry

FACILITY IDPH LICENSE NUMBER 8049116

CONTACT PERSON REGARDING THIS REPORT N/A Property Tax Exempt

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 Harvard Memorial Hospital # 8049116 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 81,155 B. General Construction Type: Exterior Brick Frame Block Number of Stories 2

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).

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	Hospital/SNF	85,800	1954	$ 3,452	1
2					2
3	TOTALS	85,800		$ 3,452	3

Facility Name & ID Number Harvard Memorial Hospital # 8049116 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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					$	$		$	$	$	4
5					SNF - Original Building cannot be broken out from hospital building						5
6											6
7											7
8											8
	Improvement Type**										
9	Metal Lockers			1976	771		20			771	9
10	Door Alarm System			1989	1,055		10			1,055	10
11	Wiring for Care Center Phones			1990	418		10			418	11
12	Activities Office			1996	19,981	1,332	15	1,332		18,093	12
13	A/C Compressor			1996	1,922	128	15	128		1,828	13
14	Cabinets			1996	11,214	561	20	561		7,901	14
15	Wandergard			1999	2,652	23	10	265	242	2,652	15
16	Construct Firewall			2003	3,761	251	15	251		1,630	16
17	Skilled Care Nurse Station			2004	9,522	635	15	635		4,126	17
18	Top Upper Cabinet			2005	1,979	198	10	198		1,088	18
19	Care Center Wiring			2005	305	43	7	43		240	19
20	Paint Rooms			2006	20,000	2,000	10	2,000		7,000	20
21	Water Heater			2007	8,620	862	10	862		3,017	21
22	Care Center Circ Line Plumbing			2008	4,676	468	10	468		1,169	22
23	Network Drops			2008	555	111	5	111		167	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 Harvard Memorial Hospital # 8049116 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 87,431	$ 6,612		$ 6,854	$ 242	$ 51,155	70

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

Facility Name & ID Number Harvard Memorial Hospital # 8049116 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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	$ 208,914	$ 17,031	$ 17,031	$		$ 73,965	71
72	Current Year Purchases	39,660	1,458	1,458			1,458	72
73	Fully Depreciated Assets	116,834					116,834	73
74								74
75	TOTALS	$ 365,408	$ 18,489	$ 18,489	$		$ 192,257	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	N/A			$	$	$	$		$	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)	$ 456,291	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 25,101	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 25,343	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 242	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 243,412	85	

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Building	$ 15,915,445	$ 597,905	$ 8,907,911	86
87	Equipment	8,319,068	646,338	6,315,198	87
88	Land Improvements	679,675	22,602	444,727	88
89					89
90					90
91	TOTALS	$ 24,914,188	$ 1,266,845	$ 15,667,836	91

G. Construction-in-Progress

	Description	Cost	
92	None	$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Harvard Memorial Hospital # 8049116 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: All rental equipment is short term rental

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☒ NO Terms: *

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: $ 4,045 Description: Copier - $2,007, Oxygen - $236, Therapy Equip - $1,802
(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		N/A	$	$	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 Harvard Memorial Hospital # 8049116 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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 Harvard Memorial Hospital # 8049116 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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		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): N/A All paid as Staff Wages									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 Harvard Memorial Hospital # 8049116 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2010 (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	$ 705,398	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 6,122,550)	3,252,830		3
4	Supply Inventory (priced at)	681,410		4
5	Short-Term Investments			5
6	Prepaid Insurance	102,497		6
7	Other Prepaid Expenses	58,736		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,800,871	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	902,279		13
14	Buildings, at Historical Cost	16,002,877		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	8,684,475		16
17	Accumulated Depreciation (book methods)	(15,911,248)		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): Debt Issuance Costs	27,849		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 9,706,232	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 14,507,103	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 417,282	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	691,710		30
31	Accrued Taxes Payable (excluding real estate taxes)	29,030		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	3,554		35
	Other Current Liabilities(specify):			
36	Other Current Liabilities	80,959		36
37	Third Party Payables	87,262		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,309,797	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	15,884,121		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)**	$ 15,884,121	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 17,193,918	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,686,815)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 14,507,103	$	48

***(See instructions.)**

Facility Name & ID Number Harvard Memorial Hospital **#** 8049116 **Report Period Beginning:** 7/1/2009 **Ending:** 6/30/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (3,033,170)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (3,033,170)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	346,355	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)**	$ 346,355	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)**	$ (2,686,815)	24 *

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

Facility Name & ID Number Harvard Memorial Hospital # 8049116 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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	$ 52,628,315	1
2	Discounts and Allowances for all Levels	(29,396,747)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 23,231,568	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		13
14	Non-Patient Meals	93,501	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	6,782	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 100,283	23
	D. Non-Operating Revenue		
24	Contributions	(938)	24
25	Interest and Other Investment Income***	5,848	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,910	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Non Op Income (Rent & Misc)	12,648	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 12,648	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 23,349,409	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,174,843	31
32	Health Care	12,394,255	32
33	General Administration	4,343,000	33
	B. Capital Expense		
34	Ownership	2,203,494	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37	Bad Debt	1,887,462	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 23,003,054	40
41	**Income before Income Taxes (line 30 minus line 40)****	346,355	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 346,355	43

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

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

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

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

Facility Name & ID Number Harvard Memorial Hospital # 8049116 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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	3,828	4,380	$ 225,159	$ 51.41	1
2	Assistant Director of Nursing					2
3	Registered Nurses	75,051	84,179	3,397,991	40.37	3
4	Licensed Practical Nurses	3,133	3,578	70,057	19.58	4
5	CNAs & Orderlies	31,270	35,646	508,059	14.25	5
6	CNA Trainees					6
7	Licensed Therapist	15,184	18,047	669,848	37.12	7
8	Rehab/Therapy Aides	2,675	2,919	39,348	13.48	8
9	Activity Director	1,696	1,837	26,801	14.59	9
10	Activity Assistants	2,376	2,734	38,280	14.00	10
11	Social Service Workers	2,424	2,755	64,707	23.49	11
12	Dietician	2,966	3,292	76,589	23.27	12
13	Food Service Supervisor	3,789	4,265	80,428	18.86	13
14	Head Cook	1,823	2,136	31,990	14.98	14
15	Cook Helpers/Assistants	18,820	21,648	211,752	9.78	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	16,223	18,307	215,952	11.80	18
19	Laundry		128	1,229	9.60	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	11,290	12,903	230,603	17.87	22
23	Office Manager					23
24	Clerical	14,179	15,708	239,984	15.28	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	808	808	71,009	87.88	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	14,489	16,290	394,062	24.19	31
32	Other Health Care(specify)	59,221	66,181	1,922,084	29.04	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	281,245	317,741	$ 8,515,932 *	$ 26.80	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	29	$ 1,543	10-3	50
51	Licensed Practical Nurses	32	1,528	10-3	51
52	Certified Nurse Assistants/Aides	708	22,847	10-3	52
53	TOTAL (lines 50 - 52)	769	$ 25,918		53

Facility Name & ID Number Harvard Memorial Hospital # 8049116 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Clerical Staff	Clerk	0	$ 49,866
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 49,866

B. Administrative - Other

Description	Amount
Hospital Assessment Tax	$ 194,358
Memberships & Dues	45,205
Admin Salaries/Interco Rent (net)	(20,382)
Other Allocations	20,652
TOTAL (agree to Schedule V, line 17, col. 3)	$ 239,833
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
WIPFLI	Audit Fees	$ 5,000
WIPFLI	Consulting Fees	8,200
IL Charity Bureau	Annual Return	15
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 13,215

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 61,046
Unemployment Compensation Insurance	18,780
FICA Taxes	623,230
Employee Health Insurance	944,161
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life & Disability Insurance	39,638
Pension	286,203
Employer TDA Match	92,902
Accrued Paid Leave	3,262
Employee Health & Other Benefits	13,784
Allocated to Ancillary Centers (col 5)	(304,459)
Allocated to Non SNF Areas (col 7)	(1,464,155)
TOTAL (agree to Schedule V, line 22, col.8)	$ 314,392

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

Description	Line #	Amount
		$
TOTAL		$

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	
Professional Memberships & Dues	56,510
Publications	1,918
Allocated to Non SNF Areas	(28,706)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 29,722

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	15,116
Seminar Expense	17,568
Allocated to Non SNF Areas	(16,058)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 16,626

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Harvard Memorial Hospital # 8049116 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Harvard Memorial Hospital **#** 8049116 **Report Period Beginning:** 7/1/2009 **Ending:** 6/30/2010

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? **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? **12**

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

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **24,638**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **Non** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **93,501**

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

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **WIPFLI**

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

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