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: 0003103

Facility Name: Memorial Care Center

Address: 4315 Memorial Drive (Number) Belleville (City) 62226 (Zip Code)

County: St. Clair

Telephone Number: (618)233-7750 **Fax #** (618)257-6839

HFS ID Number:

Date of Initial License for Current Owners: 03/01/1964

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	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: Valorie Comley **Telephone Number:** (618)257-5613
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Joe H. Lanius
(Title) Vice President - Finance

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 Memorial Care Center # 0003103 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

III. STATISTICAL DATA

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

	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	108	Skilled (SNF)	108	39,420	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	108	TOTALS	108	39,420	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	1,060		20,356	21,416	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	1,060		20,356	21,416	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 54.33%

D. How many bed-hold days during this year were paid by the Department?
None (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 03/03/1964

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 108 and days of care provided 12,774

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number Memorial Care Center # 0003103 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	412,738	2,400		415,138		415,138	131,774	546,912			1
2	Food Purchase		244,293		244,293		244,293		244,293			2
3	Housekeeping	107,633	17,365		124,998		124,998	53,652	178,650			3
4	Laundry		49,150		49,150		49,150	73,237	122,387			4
5	Heat and Other Utilities			83,157	83,157	(1,407)	81,750		81,750			5
6	Maintenance	70,229	34,159		104,388		104,388	25,357	129,745			6
7	Other (specify):*											7
8	TOTAL General Services	590,600	347,367	83,157	1,021,124	(1,407)	1,019,717	284,020	1,303,737			8
	B. Health Care and Programs											
9	Medical Director					7,498	7,498		7,498			9
10	Nursing and Medical Records	3,242,591	460,961	17,226	3,720,778	1,972	3,722,750	85,768	3,808,518			10
10a	Therapy	989,917	34,390		1,024,307		1,024,307	843,596	1,867,903			10a
11	Activities	44,880	7,215		52,095		52,095		52,095			11
12	Social Services	74,123			74,123		74,123	99,439	173,562			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,351,511	502,566	17,226	4,871,303	9,470	4,880,773	1,028,803	5,909,576			16
	C. General Administration											
17	Administrative	42,235			42,235	(7,498)	34,737		34,737			17
18	Directors Fees											18
19	Professional Services			5,500	5,500		5,500		5,500			19
20	Dues, Fees, Subscriptions & Promotions			5,664	5,664		5,664		5,664			20
21	Clerical & General Office Expenses	71,954		45,140	117,094	(565)	116,529	511,040	627,569			21
22	Employee Benefits & Payroll Taxes			928,140	928,140		928,140	366,239	1,294,379			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			63,317	63,317		63,317		63,317			26
27	Other (specify):* Bad Debts			12,700	12,700		12,700	(12,700)				27
28	TOTAL General Administration	114,189		1,060,461	1,174,650	(8,063)	1,166,587	864,579	2,031,166			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,056,300	849,933	1,160,844	7,067,077		7,067,077	2,177,402	9,244,479			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 Memorial Care Center #0003103 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			143,279	143,279		143,279	74,611	217,890			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			143,279	143,279		143,279	74,611	217,890			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	178,381	287,007		465,388		465,388	169,485	634,873			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			59,292	59,292		59,292		59,292			42
43	Other (specify):*	74,677	70,893	10,232	155,802		155,802	264,076	419,878			43
44	**TOTAL Special Cost Centers**	253,058	357,900	69,524	680,482		680,482	433,561	1,114,043			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,309,358	1,207,833	1,373,647	7,890,838		7,890,838	2,685,574	10,576,412			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 Memorial Care Center # 0003103 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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	(12,700)	27		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				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (12,700)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	2,698,274		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 2,698,274		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 2,685,574		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

Memorial Care Center

ID# 0003103

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Memorial Care Center **#** 0003103 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	0	131,774	0	0	0	0	0	0	0	0	0	131,774	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	53,652	0	0	0	0	0	0	0	0	0	53,652	3
4	Laundry	0	73,237	0	0	0	0	0	0	0	0	0	73,237	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	25,357	0	0	0	0	0	0	0	0	0	25,357	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	284,020	0	0	0	0	0	0	0	0	0	284,020	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	85,768	0	0	0	0	0	0	0	0	0	85,768	10
10a	Therapy	0	843,596	0	0	0	0	0	0	0	0	0	843,596	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	99,439	0	0	0	0	0	0	0	0	0	99,439	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**	0	1,028,803	0	0	0	0	0	0	0	0	0	1,028,803	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	0	511,040	0	0	0	0	0	0	0	0	0	511,040	21
22	Employee Benefits & Payroll Taxes	0	366,239	0	0	0	0	0	0	0	0	0	366,239	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(12,700)	0	0	0	0	0	0	0	0	0	0	(12,700)	27
28	**TOTAL General Administration**	(12,700)	877,279	0	0	0	0	0	0	0	0	0	864,579	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(12,700)	2,190,102	0	0	0	0	0	0	0	0	0	2,177,402	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Memorial Care Center # 0003103 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	74,611	0	0	0	0	0	0	0	0	0	74,611	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	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**	0	74,611	0	0	0	0	0	0	0	0	0	74,611	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	169,485	0	0	0	0	0	0	0	0	0	169,485	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	264,076	0	0	0	0	0	0	0	0	0	264,076	43
44	**TOTAL Special Cost Centers**	0	433,561	0	0	0	0	0	0	0	0	0	433,561	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(12,700)	2,698,274	0	0	0	0	0	0	0	0	0	2,685,574	45

Facility Name & ID Number Memorial Care Center # 0003103 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

VII. RELATED PARTIES

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

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

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	22	Employee Benefits	$ 928,140	Memorial Hospital	0.00%	$ 1,294,379	$ 366,239	1
2	V	21	Administration	225,747			736,787	511,040	2
3	V	6	Maintenance	186,138			211,495	25,357	3
4	V	4	Laundry	49,150			122,387	73,237	4
5	V	3	Housekeeping	124,998			178,650	53,652	5
6	V	1	Dietary	659,431			791,205	131,774	6
7	V	39	Pharmacy,Medical Supplies	465,388			634,873	169,485	7
8	V	43	Ancillary Services	155,802			419,878	264,076	8
9	V	12	Social Service	68,820			168,259	99,439	9
10	V	10	Medical Records	1,972			87,740	85,768	10
11	V	10a	Therapy	1,024,307			1,867,903	843,596	11
12	V	30	Depreciation	143,279			217,890	74,611	12
13	V								13
14	Total			$ 4,033,172			$ 6,731,446	$ * 2,698,274	14

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

Facility Name & ID Number Memorial Care Center # 0003103 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Not Applicable								$		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 Memorial Care Center # 0003103 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Emp Ben - Nursing & Med Dir	Salaries	93,948,764	2	$ 36,527,627	$ 918,040	3,075,620	$ 1,195,812	1
2	21	Patient Accounts	Revenue	799,798,125	2	3,850,441	1,396,867	4,312,310	20,761	2
3	21	Communications	Phones	1,498	2	558,013	223,176	24	8,940	3
4	21	Data Processing	Resources	10,000	2	3,702,802	1,187,353	70	25,920	4
5	21	Materials Management	Stores Requisitions	5,042,568	2	861,210	558,087	190,592	32,551	5
6	21	Administration	Accumulated Cost	202,528,264	2	24,963,527	5,460,760	5,262,188	648,615	6
7	6	Plant	Square Feet	18,453	2	242,121	70,229	16,119	211,497	7
8	4	Laundry	Pounds	2,201,638	2	1,363,393	441,897	197,634	122,387	8
9	3	Housekeeping	Hours of Service	117,551	2	3,102,668	1,664,262	0	0	9
10	3	Housekeeping MCC	Square Feet	17,705	2	196,229	107,633	16,119	178,651	10
11	1	Dietary	Patient Meals	251,244	2	3,094,033	1,467,570	64,248	791,205	11
12	22	Emp Ben - Cafeteria	Employee Meals	193,158	2	1,900,219	792,295	9,723	95,651	12
13	10	Medical Records	Time Spent	10,000	2	5,161,170	2,127,586	170	87,740	13
14	12	Social Service	Time Spent	1,758,500	2	1,135,093	631,543	260,670	168,260	14
15	43	Radiology	Revenue	168,560,025	2	15,060,882	3,915,802	222,588	19,888	15
16	43	Laboratory	Revenue	122,781,654	2	16,518,315	4,830,305	1,189,098	159,974	16
17	43	Nutritional Support	Revenue	5,887	2	384,571	218,097	3,540	231,252	17
18	43	EKG	Revenue	33,502,049	2	2,517,740	1,218,004	116,622	8,764	18
19	39	Drugs & IV Therapy	Revenue	69,038,948	2	14,226,929	2,742,402	2,966,109	611,229	19
20	39	Medical Supplies Sold	Revenue	15,442,122	2	2,945,645	577,331	123,952	23,644	20
21	10a	Respiratory Care	Revenue	42,003,418	2	4,198,016	2,132,932	1,414,432	141,365	21
22	10a	Physical Therapy	Revenue	29,287,449	2	7,095,306	3,930,261	4,234,061	1,025,762	22
23	10a	Occupational Therapy	Revenue	5,010,461	2	1,117,202	551,339	2,722,260	606,993	23
24	10a	Speech Therapy	Revenue	1,026,303	2	449,043	258,818	214,345	93,783	24
25	TOTALS					$ 151,172,195	$ 37,422,589		$ 6,510,644	25

Facility Name & ID Number Memorial Care Center # 0003103 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	Capital Costs	See Attached	9,164,027		$ 9,164,027	$	217,890	$ 217,890	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 9,164,027	$		$ 217,890	25

Facility Name & ID Number Memorial Care Center # 0003103 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2				Not Applicable								2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	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 Memorial Care Center **#** 0003103 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	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 Memorial Care Center COUNTY St. Clair

FACILITY IDPH LICENSE NUMBER 0003103

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 Memorial Care Center # 0003103 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,001 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).

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			1964	$ 40,000	1
2					2
3	TOTALS			$ 40,000	3

Facility Name & ID Number Memorial Care Center # 0003103 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	108		1964	1964	$ 882,395	$		$	$	$ 882,395	4
5			1979		83,787	1,582	25	1,582		72,717	5
6											6
7											7
8											8
	Improvement Type**										
9	Electrical Upgrade			1996	25,549	1,359		1,359		19,694	9
10	Walking Track			1998	7,690	512	15	512		6,410	10
11	Roof Replacement			1998	68,383		10			68,383	11
12	Change in Electrical power system			1998	5,479	366	15	366		4,566	12
13	7 1/2 ton AC unit			1998	14,326	955	15	955		11,938	13
14	Air furnace			1998	15,226	1,015	15	1,015		12,668	14
15	5 ton air handler			1998	14,900	993	15	993		12,416	15
16	Electrical work-boiler room, AC unit,relamp, auto tr switch			1998	91,162	4,559	20	4,559		56,972	16
17	Air handling unit installed			1994	12,048		15			12,048	17
18	Repair parking lot			1994	83,569	494	10.85	494		81,840	18
19	Landscaping			1994	4,200		15			4,200	19
20	Flooring replaced patient room			1993	56,883		15			56,883	20
21	Activity Therapy renovation			1993	40,864	447	12.83	447		39,032	21
22	Condensing unit			1993	4,684		15			4,684	22
23	Air conditioners			1993	6,589		15			6,589	23
24	Upgrade lighting			1993	4,516	225	20	225		3,952	24
25	Renovate patient room & nurse station			1992	42,054	1,441	17.99	1,441		39,890	25
26	Renovate patient rooms-doors, wallcovering			1992	75,020		10.49			75,020	26
27	Roof top air conditioner			1992	4,342		15			4,342	27
28	Renovate business office			1991	34,447	1,057	18.5	1,057		33,919	28
29	Patient rooms-drywall,ceiling,paint			1991	39,029	99	14.55	99		38,979	29
30	Brickwork chimney			1991	5,225		15			5,225	30
31	Paint exterior tower			1991	1,185		5			1,185	31
32	ITE panel			1991	995	49	20	49		970	32
33	Air conditioners			1991	6,580		15			6,580	33
34	Circuit Breaker			1991	1,011	51	20	51		986	34
35	Vinyl flooring restrooms			1999	2,441		5			2,441	35
36	Land improvements			1968	2,170		40			2,170	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 Memorial Care Center # 0003103 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Reznor make up air unit	1999	$ 15,432	$	10	$	$	$ 15,432	37
38	Electrical work	1999	2,566	129	20	129		1,474	38
39	New door physical therapy	2000	3,735	249	15	249		2,615	39
40	Porch columns	2000	5,965	397	15	397		4,176	40
41	Repair walls	2001	2,080	138	15	138		1,318	41
42	Electrical work	2001	4,191	209	20	209		1,991	42
43	Electrical work	2001	16,778	840	20	840		7,969	43
44	Window replacement	2002	113,345	7,557	15	7,557		64,324	44
45	Storage addition	2002	253,195	16,878	15	16,878		143,477	45
46	Storage addition	2002	4,227		5			4,227	46
47	Storage addition	2002	1,259		1			1,259	47
48	Fire Alarm/Nurse Call Replacement	2002	4,473	297	15	297		2,573	48
49	Fire Alarm/Nurse Call Replacement	2002	1,001		5			1,001	49
50	Fire Alarm/Nurse Call Replacement	2002	48,125	4,813	10	4,813		40,906	50
51	Fire Alarm/Nurse Call Replacement	2002	490	33	15	33		279	51
52	Fire Alarm/Nurse Call Replacement	2002	61,775	3,089	20	3,089		26,253	52
53	Patient Wardrobe Units	2002	67,813	4,520	15	4,520		38,428	53
54	Patient Wardrobe Units	2002	5,824	582	10	582		4,950	54
55	Heating and Cooling Unit	2002	7,702	513	15	513		4,364	55
56	8" Faucets	2002	5,318	266	20	266		2,261	56
57	Window Replacement	2003	75	5	15	5		38	57
58	Storage Addition	2003	138	9	15	9		68	58
59	Fire Alarm/Nurse Call Replacement	2003	659	66	10	66		495	59
60	Window Replacement	2003	16,451	1,097	15	1,097		8,227	60
61	Patient Wardrobe Units	2003	16,789	839	20	839		6,295	61
62	Fire Alarm/Nurse Call Replacement	2003	19,745	987	20	987		7,403	62
63	Utility Storage Room Plumbing Work	2004	776	40	20	40		250	63
64	Beauty Shop/Utility Room Renovations	2004	4,626	231	20	231		1,502	64
65	Roof	2005	4,910	245	20	245		1,350	65
66	Rooftop Air Handler - 100 Hallway	2006	9,500	950	10	950		4,275	66
67	Doors	2006	6,500	650	10	650		2,925	67
68	Bell Tower Restoration	2006	6,935	462	15	462		2,079	68
69	Renovations - walls and ceilings	2006	22,329	1,489	15	1,489		6,700	69
70	TOTAL (lines 4 thru 69)		$ 2,371,476	$ 62,784		$ 62,784	$	$ 1,979,978	70

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

Facility Name & ID Number Memorial Care Center # 0003103 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,371,476	$ 62,784		$ 62,784	$	$ 1,979,978	1
2	Renovations - electrical	2006	19,033	952	20	952		4,284	2
3	Renovations - painting	2006	1,142	229	5	229		1,028	3
4	Renovations - fire dampers	2006	12,726	636	20	636		2,862	4
5	Doors	2007	7,033	703	10	703		2,461	5
6	Rooftop Air Handler	2007	9,500	475	20	475		1,663	6
7	Interior Doors	2007	9,508	951	10	951		3,329	7
8	Doors	2008	1,152	115	10	115		288	8
9	Renovations - Storage Room Electrical	2009	3,895	195	20	195		292	9
10	Renovations - Occup Therapy Structural Design Work Walls	2009	3,460	231	15	231		346	10
11	Heating and Cooling Unit	2009	31,460	2,097	15	2,097		3,146	11
12	Renovations - painting/flooring Occup Therapy	2009	4,574	915	5	915		1,372	12
13	Renovations - Occup Therapy Kwik Wall Accordian Door	2009	5,535	369	15	369		554	13
14	Renovations - Occup Therapy Carpentry Work Walls	2009	7,911	527	15	527		791	14
15	Soffet/Facia North Entrance	2010	3,970	99	20	99		99	15
16	Chapel Entrance Construction	2010	16,610	415	20	415		415	16
17	Schematic Design Svcs	2010	31,268	1,042	15	1,042		1,042	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)		$ 2,540,253	$ 72,735		$ 72,735	$	$ 2,003,950	34

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

Facility Name & ID Number Memorial Care Center # 0003103 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 654,094	$ 65,853	$ 65,853	$		$ 381,731	71
72	Current Year Purchases	70,163	4,692	4,692			4,692	72
73	Fully Depreciated Assets	311,140					311,140	73
74								74
75	TOTALS	$ 1,035,397	$ 70,545	$ 70,545	$		$ 697,563	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		2000 Ford Bus	2000	$ 49,174	$	$	$		$ 49,174	76
77										77
78										78
79										79
80	TOTALS			$ 49,174	$	$	$		$ 49,174	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)	$ 3,664,824	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 143,280	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 143,280	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)	$ 2,750,687	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 Memorial Care Center # 0003103 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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: $ 171,915 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 Memorial Care Center # 0003103 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Memorial Care Center # 0003103 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a	hrs	$ 344,762		$	$ 9,871		$ 354,633	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	hrs	521,343			3,734		525,077	4
5	Physician Care		visits		46	13,517		46	13,517	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts	178,381			287,007		465,388	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			$ 1,044,486	46	$ 13,517	$ 300,612	46	$ 1,358,615	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 Memorial Care Center # 0003103 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

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

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 325	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 2,226,903)	2,166,534		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	4,528		6
7	Other Prepaid Expenses	5,664		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from Medicare	10,545		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,187,596	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	40,000		13
14	Buildings, at Historical Cost	2,444,618		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,084,746		16
17	Accumulated Depreciation (book methods)	(2,750,687)		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): Land Improvements	95,459		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 914,136	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,101,732	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 134,987	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	213,881		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				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 348,868	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Reserves for Self Insurance	708,016		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 708,016	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,056,884	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,044,848	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,101,732	$	48

*(See instructions.)

Facility Name & ID Number Memorial Care Center # 0003103 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,352,194	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,352,194	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	595,384	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)**	$ 595,384	17
	B. Transfers (Itemize):		
18	**Interfund Transfer - Hospital**	97,270	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 97,270	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,044,848	24 *

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

Facility Name & ID Number Memorial Care Center # 0003103 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,312,310	1
2	Discounts and Allowances for all Levels	(9,035,631)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ (4,723,321)	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	7,170,667	6
7	Oxygen	1,414,432	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 8,585,099	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		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	2,966,109	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,189,098	19
20	Radiology and X-Ray	222,588	20
21	Other Medical Services	244,114	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 4,621,909	23
	D. Non-Operating Revenue		
24	Contributions	2,535	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,535	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,486,222	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,019,717	31
32	Health Care	4,880,773	32
33	General Administration	1,166,587	33
	B. Capital Expense		
34	Ownership	143,279	34
	C. Ancillary Expense		
35	Special Cost Centers	621,190	35
36	Provider Participation Fee	59,292	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,890,838	40
41	**Income before Income Taxes (line 30 minus line 40)****	595,384	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 595,384	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 Memorial Care Center # 0003103 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,798	2,086	$ 97,384	$ 46.68	1
2	Assistant Director of Nursing	1,853	2,134	78,853	36.95	2
3	Registered Nurses	38,560	47,373	1,552,969	32.78	3
4	Licensed Practical Nurses	7,538	8,787	191,632	21.81	4
5	CNAs & Orderlies	60,165	74,823	1,035,513	13.84	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,655	3,015	44,880	14.89	10
11	Social Service Workers	2,614	3,030	74,123	24.46	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	27,188	32,073	412,739	12.87	15
16	Dishwashers					16
17	Maintenance Workers	3,115	3,528	70,229	19.91	17
18	Housekeepers	8,523	9,786	107,633	11.00	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator	266	299	34,736	116.17	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,203	18,189	356,222	19.58	24
25	Vocational Instruction	11,141	12,765	344,762	27.01	25
26	Academic Instruction					26
27	Medical Director	89	103	7,498	72.80	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	103	115	1,972	17.15	31
32	Other Health Care(specify)	31,187	35,449	898,213	25.34	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	211,998	253,555	$ 5,309,358 *	$ 20.94	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			3,649	Line 10 Col 3	47
48					48
49	TOTAL (lines 35 - 48)		$ 3,649		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	2,354	$ 142,720	Line 10 Col 1	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	5,210	111,320	Line 10 Col 1	52
53	TOTAL (lines 50 - 52)	7,564	$ 254,040		53

Facility Name & ID Number Memorial Care Center # 0003103 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Joe Lanius	VP - Finance		$ 13,547
Nancy Weston	VP - Nursing		21,190
Dr. William Casperson	Medical Director		7,498
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 42,235

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
BKD, LLP	Audit Fees	$ 5,500
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 5,500

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$

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	
Illinois Health Care	5,664
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,664

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 Memorial Care Center # 0003103 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

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

Facility Name & ID Number Memorial Care Center **#** 0003103 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care $5,664**

(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? **6.2**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **23,294** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **59,292**
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. $ **95,651** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,269,407**

(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? **None**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Not Applicable**
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: **BKD, 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? **Not applicable**
Attach invoices and a summary of services for all architect and appraisal fees.