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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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) 257-6931

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: Melissa Hubler **Telephone Number:** (618) 257-5606
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 01/01/2014 to 12/31/2014 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) Amy L. Thomas
(Title) Vice President-Finance

Paid Preparer

(Signed) _____ 04/28/15 (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: 01/01/2014 Ending: 12/31/2014

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)	82	33,050	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	82	33,050	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	52		22,843	22,895	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	52		22,843	22,895	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.27%

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 15,294

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: 12/31/2014 Fiscal Year: 12/31/2014

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

Facility Name & ID Number Memorial Care Center # 0003103 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	440,874	2,400		443,274		443,274	155,256	598,530			1
2	Food Purchase		302,913		302,913		302,913		302,913			2
3	Housekeeping	120,178	16,787		136,965		136,965	115,074	252,039			3
4	Laundry		48,353		48,353		48,353	35,946	84,299			4
5	Heat and Other Utilities			87,873	87,873	(2,400)	85,473		85,473			5
6	Maintenance	70,022	63,208		133,230		133,230	33,429	166,659			6
7	Other (specify):*											7
8	TOTAL General Services	631,074	433,661	87,873	1,152,608	(2,400)	1,150,208	339,705	1,489,913			8
	B. Health Care and Programs											
9	Medical Director					8,814	8,814		8,814			9
10	Nursing and Medical Records	3,597,198	417,137	15,068	4,029,403	1,990	4,031,393	66,139	4,097,532			10
10a	Therapy	1,329,814	40,964		1,370,778		1,370,778	1,904,149	3,274,927			10a
11	Activities	54,934	7,761		62,695		62,695		62,695			11
12	Social Services	73,086			73,086		73,086	77,132	150,218			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	5,055,032	465,862	15,068	5,535,962	10,804	5,546,766	2,047,420	7,594,186			16
	C. General Administration											
17	Administrative	45,002			45,002	(8,814)	36,188		36,188			17
18	Directors Fees											18
19	Professional Services			5,800	5,800		5,800		5,800			19
20	Dues, Fees, Subscriptions & Promotions			5,962	5,962		5,962		5,962			20
21	Clerical & General Office Expenses	71,902		2,294	74,196	410	74,606	891,358	965,964			21
22	Employee Benefits & Payroll Taxes			1,063,449	1,063,449		1,063,449	386,978	1,450,427			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			65,788	65,788		65,788		65,788			26
27	Other (specify):*											27
28	TOTAL General Administration	116,904		1,143,293	1,260,197	(8,404)	1,251,793	1,278,336	2,530,129			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,803,010	899,523	1,246,234	7,948,767		7,948,767	3,665,461	11,614,228			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:** 01/01/2014 **Ending:** 12/31/2014

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			483,558	483,558		483,558		483,558			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			373,141	373,141		373,141		373,141			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* **Bond Issue Expense**			1,994	1,994		1,994		1,994			36
37	**TOTAL Ownership**			858,693	858,693		858,693		858,693			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	227,011	467,098		694,109		694,109	450,573	1,144,682			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			90,844	90,844		90,844		90,844			42
43	Other (specify):*	81,436	90,430		171,866		171,866	110,707	282,573			43
44	**TOTAL Special Cost Centers**	308,447	557,528	90,844	956,819		956,819	561,280	1,518,099			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,111,457	1,457,051	2,195,771	9,764,279		9,764,279	4,226,741	13,991,020			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: 01/01/2014 Ending: 12/31/2014

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				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$		$	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)	4,226,741		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 4,226,741		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 4,226,741		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: 01/01/2014

Ending: 12/31/2014

	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:** 01/01/2014 **Ending:** 12/31/2014

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

	Operating Expenses	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)	
	A. General Services													
1	Dietary	0	155,256	0	0	0	0	0	0	0	0	0	155,256	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	115,074	0	0	0	0	0	0	0	0	0	115,074	3
4	Laundry	0	35,946	0	0	0	0	0	0	0	0	0	35,946	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	33,429	0	0	0	0	0	0	0	0	0	33,429	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	339,705	0	0	0	0	0	0	0	0	0	339,705	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	66,139	0	0	0	0	0	0	0	0	0	66,139	10
10a	Therapy	0	1,904,149	0	0	0	0	0	0	0	0	0	1,904,149	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	77,132	0	0	0	0	0	0	0	0	0	77,132	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	2,047,420	0	0	0	0	0	0	0	0	0	2,047,420	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	891,358	0	0	0	0	0	0	0	0	0	891,358	21
22	Employee Benefits & Payroll Taxes	0	386,978	0	0	0	0	0	0	0	0	0	386,978	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	1,278,336	0	0	0	0	0	0	0	0	0	1,278,336	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	3,665,461	0	0	0	0	0	0	0	0	0	3,665,461	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Memorial Care Center # 0003103 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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

	Capital Expense D. Ownership	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)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	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	0	0	0	0	0	0	0	0	0	0	0	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	450,573	0	0	0	0	0	0	0	0	0	450,573	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	110,707	0	0	0	0	0	0	0	0	0	110,707	43
44	**TOTAL Special Cost Centers**	0	561,280	0	0	0	0	0	0	0	0	0	561,280	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	0	4,226,741	0	0	0	0	0	0	0	0	0	4,226,741	45

Facility Name & ID Number Memorial Care Center # 0003103 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

VII. RELATED PARTIES

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

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

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

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

1 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	$ 1,063,449	Memorial Hospital		$ 1,450,427	$ 386,978	1
2	V	21	Administration	185,640			1,076,998	891,358	2
3	V	6	Maintenance	218,680			252,109	33,429	3
4	V	4	Laundry	48,353			84,299	35,946	4
5	V	3	Housekeeping	136,965			252,039	115,074	5
6	V	1	Dietary	746,187			901,443	155,256	6
7	V	39	Pharmacy,Medical Supplies	694,109			1,144,682	450,573	7
8	V	43	Ancillary Services	171,866			282,573	110,707	8
9	V	12	Social Service	73,086			150,218	77,132	9
10	V	10	Medical Records	1,990			68,129	66,139	10
11	V	10a	Therapy	1,273,134			3,177,283	1,904,149	11
12	V	30	Depreciation	483,558			483,558		12
13	V								13
14	Total			$ 5,097,017			$ 9,323,758	$ * 4,226,741	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: 01/01/2014 Ending: 12/31/2014

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											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: 01/01/2014 Ending: 2/31/2014

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	91,207,178	2	$ 36,393,027	$ 1,158,453	3,430,723	$ 1,368,910	1
2	21	Patient Accounts	Revenue	1,090,650,850	2	4,425,190	1,292,527	6,136,258	24,897	2
3	21	Communications	Phones	1,562	2	595,723	244,299	30	11,442	3
4	21	Data Processing	Resources	10,000	2	5,414,395	1,679,571	215	116,409	4
5	21	Materials Management	Stores Requisitions	9,935,796	2	779,615	497,391	195,059	15,305	5
6	21	Administration	Accumulated Cost	208,593,035	2	29,938,811	4,482,951	6,332,885	908,942	6
7	6	Plant	Square Feet	18,453	2	288,615	70,022	16,119	252,110	7
8	4	Laundry	Pounds	1,727,770	2	1,051,545	0	138,509	84,299	8
9	3	Housekeeping	Hours of Service	105,511	2	3,744,497	1,735,748	0	0	9
10	3	Housekeeping MCC	Square Feet	17,705	2	276,839	120,178	16,119	252,040	10
11	1	Dietary	Patient Meals	261,399	2	3,460,680	1,600,945	68,685	909,326	11
12	22	Emp-Ben - Cafeteria	Employee Meals	147,136	2	1,408,822	481,713	8,091	77,471	12
13	10	Medical Records	Time Spent	10,000	2	4,007,603	1,524,625	170	68,129	13
14	12	Social Service	Time Spent	19,461	2	1,254,136	647,507	2,331	150,218	14
15	43	Radiology	Revenue	241,981,270	2	8,221,735	4,878,065	377,584	12,829	15
16	43	Laboratory	Revenue	168,060,079	2	15,384,201	3,987,813	2,872,351	262,935	16
17	43	EKG	Revenue	58,588,612	2	3,141,230	1,376,243	126,999	6,809	17
18	39	Drugs & IV Therapy	Revenue	112,033,878	2	16,210,508	3,253,828	7,911,112	1,144,682	18
19	39	Medical Supplies Sold	Revenue	30,276,521	2	12,175,745	497,391	0	0	19
20	10a	Respiratory Care	Revenue	42,591,808	2	4,022,019	1,838,235	1,856,107	175,275	20
21	10a	Physical Therapy	Revenue	37,841,229	2	7,960,313	4,379,178	8,146,192	1,713,640	21
22	10a	Occupational Therapy	Revenue	9,894,957	2	1,510,117	754,637	6,140,651	937,154	22
23	10a	Speech Therapy	Revenue	3,233,093	2	819,111	460,779	1,386,267	351,214	23
24	30	Capital Costs	See Attached	11,310,041		11,310,041	0	450,128	450,128	24
25	TOTALS					$ 173,794,518	$ 36,962,099		$ 9,294,164	25

Facility Name & ID Number Memorial Care Center # 0003103 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	SW III Dev Authority Rev Bonds		X	Building renovation	$36,685.00	12-6-2013	$ 5,275,400	$ 4,973,348	11-1-2048	0.0734	$ 373,141	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$36,685.00		$ 5,275,400	$ 4,973,348			$ 373,141	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,275,400	$ 4,973,348			$ 373,141	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: 01/01/2014 Ending: 12/31/2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 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 2014 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:			
	2009		8
	2010		9
	2011		10
	2012		11
	2013		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 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 2013 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 2013.

	(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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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: 01/01/2014 Ending: 12/31/2014

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: 01/01/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	82		1964	1964	$ 882,395	$	23	$	$	$ 882,395	4
5			1979		83,787	1,582	18	1,582		79,043	5
6											6
7											7
8											8
	Improvement Type**										
9	Electrical Upgrade			1996	25,549	1,038	20	1,038		23,997	9
10	Walking Track			1998	7,690		15			7,690	10
11	Roof Replacement			1998	68,383		10			68,383	11
12	Change in Electrical power system			1998	5,479		15			5,479	12
13	7 1/2 ton AC unit			1998	14,326		15			14,326	13
14	Air furnace			1998	15,226		15			15,226	14
15	5 ton air handler			1998	14,900		15			14,900	15
16	Electrical work-boiler room, AC unit,relamp, auto tr switch			1998	91,162	4,560	20	4,560		75,208	16
17	Air handling unit			1994	12,048		15			12,048	17
18	Repair parking lot			1994	83,569	247	15	247		83,569	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	22,993	142	5	142		22,494	21
22	Upgrade lighting			1993	4,516		20			4,516	22
23	Vinyl flooring restrooms			1999	2,441		5			2,441	23
24	Land improvements			1968	2,170		40			2,170	24
25	Reznor make up air unit			1999	15,432		10			15,432	25
26	Electrical work			1999	2,566	129	20	129		1,988	26
27	New door physical therapy			2000	3,735	249	15	249		3,611	27
28	Porch columns			2000	5,965	397	15	397		5,766	28
29	Repair walls			2001	2,080	138	15	138		1,872	29
30	Electrical work			2001	4,191	209	20	209		2,829	30
31	Electrical work			2001	16,778	840	20	840		11,325	31
32	Window replacement			2002	113,345	7,556	15	7,556		94,458	32
33	Storage addition			2002	253,195	16,876	15	16,876		210,994	33
34	Storage addition			2002	4,227		5			4,227	34
35	Storage addition			2002	1,259		1			1,259	35
36	Fire Alarm/Nurse Call Replacement			2002	4,473	298	15	298		3,728	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: 01/01/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	Fire Alarm/Nurse Call Replacement	2002	$ 1,001	$	5	$	$	$ 1,001	37
38	Fire Alarm/Nurse Call Replacement	2002	48,125		10			48,125	38
39	Fire Alarm/Nurse Call Replacement	2002	490	33	15	33		409	39
40	Fire Alarm/Nurse Call Replacement	2002	61,775	3,087	20	3,087		38,610	40
41	Patient Wardrobe Units	2002	67,813	4,519	15	4,519		56,511	41
42	Patient Wardrobe Units	2002	5,824		10			5,824	42
43	Heating and Cooling Unit	2002	7,702	513	15	513		6,418	43
44	8" Faucets	2002	5,318	266	20	266		3,325	44
45	Window Replacement	2003	75	5	15	5		58	45
46	Storage Addition	2003	138	10	15	10		105	46
47	Fire Alarm/Nurse Call Replacement	2003	659		10			659	47
48	Window Replacement	2003	16,451	1,096	15	1,096		12,614	48
49	Patient Wardrobe Units	2003	16,789	839	20	839		9,653	49
50	Fire Alarm/Nurse Call Replacement	2003	19,745	987	20	987		11,351	50
51	Utility Storage Room Plumbing Work	2004	776	40	20	40		406	51
52	Beauty Shop/Utility Room Renovations	2004	4,626	232	20	232		2,427	52
53	Roof	2005	4,910	245	20	245		2,332	53
54	Rooftop Air Handler - 100 Hallway	2006	9,500	950	10	950		8,075	54
55	Doors	2006	6,500	650	10	650		5,525	55
56	Bell Tower Restoration	2006	6,935	463	15	463		3,929	56
57	Renovations - wall and ceilings	2006	22,329	1,489	15	1,489		12,654	57
58	Renovations - Electrical	2006	19,033	952	20	952		8,091	58
59	Renovations - painting	2006	1,142		5			1,142	59
60	Renovations - fire dampers	2006	12,726	636	20	636		5,406	60
61	Doors	2007	7,033	704	10	704		5,274	61
62	Rooftop Air Handler	2007	9,500	475	20	475		3,563	62
63	Interior Doors	2007	9,508	951	10	951		7,133	63
64	Doors	2008	1,152	115	10	115		748	64
65	Renovations - Storage Room Electrical	2009	3,895	195	20	195		1,072	65
66	Renovations - Occup Therapy Structural Design Work Walls	2009	3,460	231	15	231		1,270	66
67	Heating and Cooling Unit	2009	31,460	2,097	15	2,097		11,534	67
68	Renovations -painting/flooring Occup Therapy	2009	4,574	458	5	458		4,574	68
69	Renovations - Occup Therapy Kwik Wall Accordion Door	2009	5,535	369	15	369		2,030	69
70	TOTAL (lines 4 thru 69)		$ 2,241,462	$ 56,868		$ 56,868	$	$ 2,014,305	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: 01/01/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		$ 2,241,462	$ 56,868		$ 56,868	$	$ 2,014,305	1
2	Renovations - Occup Therapy Carpentry Work Walls	2009	7,911	527		527		2,899	2
3	Soffit/Fascia North Entrance	2010	3,971	198		198		894	3
4	Chapel Entrance Construction	2010	16,610	830		830		3,737	4
5	Schematic Design Svcs	2010	31,268	2,085		2,085		9,382	5
6	Sidewalk	2012	7,000	467		467		1,167	6
7	Renovations - Construction Work Patient Rooms	2012	2,980,629	157,831		157,831		394,574	7
8	Renovations - Engineering Work Patient Rooms	2012	229,814	15,321		15,321		38,302	8
9	IDPH Plan Review - Patient Room Renovations	2012	11,000	733		733		1,833	9
10	Professional Design Services - Patient Room Renovations	2012	177,717	11,846		11,846		29,619	10
11	Renovations - Construction Work Patient Rooms	2013	1,928,633	96,431		96,431		144,649	11
12	Roof	2013	183,518	9,176		9,176		13,764	12
13	Renovations - Bathtubs	2013	12,440	622		622		933	13
14	Renovations - Construction Work Patient Rooms	2014	797,776	19,945		19,945		19,945	14
15	Renovations - Meecho shades, cornice board, step cornice	2014	11,090	1,109		1,109		1,109	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,640,838	$ 373,989		$ 373,989	$	$ 2,677,112	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: 01/01/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,007,955	$ 105,713	$ 105,713	$		$ 481,558	71
72	Current Year Purchases	34,216	2,235	2,235			2,235	72
73	Fully Depreciated Assets	443,951	1,621	1,621			443,951	73
74								74
75	TOTALS	$ 1,486,122	$ 109,569	$ 109,569	$		$ 927,744	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		2000 Ford Bus	2000	$ 49,174	$	$	$	4	$ 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)	$ 10,216,134	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 483,558	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 483,558	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)	$ 3,654,030	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: 01/01/2014 Ending: 12/31/2014

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.	/2015	$
13.	/2016	$
14.	/2017	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 102,593 Description: Attached
    (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: 01/01/2014 Ending: 12/31/2014

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: 01/01/2014 Ending: 12/31/2014

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	hrs	$ 397,813		$	$ 1,106		$ 398,919	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	hrs	154,549			12,584		167,133	4
5	Physician Care		visits		27	3,178		27	3,178	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts	227,013			467,098		694,111	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			$ 779,375	27	$ 3,178	$ 480,788	27	$ 1,263,341	14

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

Facility Name & ID Number Memorial Care Center # 0003103 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2014 (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 3,290,325)	1,984,327		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	717		6
7	Other Prepaid Expenses	70,120		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from Medicare	75,627		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,131,116	$	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	8,540,351		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,533,324		16
17	Accumulated Depreciation (book methods)	(3,654,030)		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 Impovements	102,459		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 6,562,104	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,693,220	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 146,434	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	43,708		29
30	Accrued Salaries Payable	280,045		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)**	$ 470,187	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	4,929,640		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Reserves for Self Insurance	758,020		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 5,687,660	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,157,847	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,535,373	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,693,220	$	48

***(See instructions.)**

Facility Name & ID Number Memorial Care Center **#** 0003103 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,574,719	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,574,719	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	508,870	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)**	$ 508,870	17
	B. Transfers (Itemize):		
18	**Interfund Transfer - Hospital**	(548,216)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (548,216)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,535,373	24 *

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

Facility Name & ID Number Memorial Care Center # 0003103 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,136,258	1
2	Discounts and Allowances for all Levels	(24,680,373)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ (18,544,115)	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	15,673,111	6
7	Oxygen	1,856,107	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 17,529,218	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	7,911,112	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,872,351	19
20	Radiology and X-Ray	377,584	20
21	Other Medical Services	126,999	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 11,288,046	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	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)**	$ 10,273,149	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,152,608	31
32	Health Care	5,535,962	32
33	General Administration	1,260,197	33
	B. Capital Expense		
34	Ownership	858,693	34
	C. Ancillary Expense		
35	Special Cost Centers	865,975	35
36	Provider Participation Fee	90,844	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,764,279	40
41	**Income before Income Taxes (line 30 minus line 40)****	508,870	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 508,870	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ (123,995)	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue	(13,677,687)	46
47	Other-(specify)	(4,742,433)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ (18,544,115)	49

* **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: 01/01/2014 Ending: 12/31/2014

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	1,827	2,083	$ 92,307	$ 44.31	1
2	Assistant Director of Nursing					2
3	Registered Nurses	44,131	52,496	1,861,008	35.45	3
4	Licensed Practical Nurses	7,392	8,472	184,476	21.77	4
5	CNAs & Orderlies	60,677	69,565	990,359	14.24	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,983	3,401	54,934	16.15	10
11	Social Service Workers	2,340	2,754	73,086	26.54	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	29,363	34,008	440,874	12.96	15
16	Dishwashers					16
17	Maintenance Workers	2,979	3,528	70,022	19.85	17
18	Housekeepers	9,163	10,277	120,178	11.69	18
19	Laundry					19
20	Administrator	1,725	1,997	101,767	50.96	20
21	Assistant Administrator	262	300	36,188	120.63	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	17,305	19,661	437,300	22.24	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	95	105	8,814	83.94	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	104	117	1,990	17.01	31
32	Other Health Care(specify)	51,600	59,114	1,638,154	27.71	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	231,946	267,878	$ 6,111,457 *	$ 22.81	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			11,890	Line 10 Col 3	47
48					48
49	TOTAL (lines 35 - 48)		$ 11,890		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,962	$ 128,759	Line 10 Col 1	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	4,255	90,660	Line 10 Col 1	52
53	TOTAL (lines 50 - 52)	6,217	$ 219,419		53

Facility Name & ID Number Memorial Care Center # 0003103 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Amy Thomas	VP-Finance		$ 14,113
Nancy Weston	VP-Nursing		22,075
Dr. William Casperson	Medical Director		8,814
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 45,002

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	$ 5,800
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 5,800

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)	
Illinois Health Care	5,962
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,962

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: 01/01/2014 Ending: 12/31/2014

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: 01/01/2014 Ending: 12/31/2014

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 $5,962**

(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? **8**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **10,434** 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. $ **90,844**
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. $ **77,471** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,130,101**

(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. $ **No**

(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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Not Applicable**
Attach invoices and a summary of services for all architect and appraisal fees.

MEMORIAL CARE CENTER
PAGE 3, SCH V RECLASSIFICATION ENTRIES
12/31/14

SCH V LINE#		INCREASE	DECREASE
9	MEDICAL DIRECTOF	8,814	
17	ADMINISTRATION		(8,814)
	To reclassify Medical Director's salary		
10	NURSING AND MEDI	1,990	
21	CLERICAL & GENERAL		(1,990)
	To reclassify Medical Records' salaries		
21	CLERICAL & GENER	2,400	
5	HEAT & OTHER UTILITIES		(2,400)
	To reclassify cost of telephones		

MEMORIAL CARE CENTER
OTHER ANCILLARY SERVICE CENTERS
PAGE 3, SCH V - COST CENTER EXPENSE
12/31/14

LINE 10 - DESCRIPTION	HOURS	SALARY	SUPPLIES	OTHER	TOTAL
NURSING		3,377,779	417,137	0	3,794,916
PHYSICIAN FEES				15,068	15,068
CONTRACT RN'S (pg 20 C, Ln 50)	1,961.50	128,759			128,759
CONTRACT NA'S (pg 20 C, Ln 52)	4,255.25	90,660		0	90,660
		3,597,198	417,137	15,068	4,029,403

MEMORIAL CARE CENTER
OTHER ANCILLARY SERVICE CENTERS
PAGES 3-4, SCH V - COST CENTER EXPENSE
12/31/14

LINE 43 - DESCRIPTION	SALARY	SUPPLIES	OTHER	TOTAL
NUTRITIONAL SUPPORT	0	0	0	0
LABORATORY	65,960	85,805	0	151,765
RADIOLOGY	12,545	4,293	0	16,838
ELECTROCARDIOLOGY	2,931	332	0	3,263
	81,436	90,430	0	171,866

LINE 10a - DESCRIPTION	SALARY	SUPPLIES	OTHER	TOTAL
RESPIRATORY CARE	77,400	22,948	0	100,348
SPEECH THERAPY	154,549	4,326	0	158,875
PHYSICAL THERAPY	700,052	12,584	0	712,636
OCCUPATIONAL THERAPY	397,813	1,106	0	398,919
	1,329,814	40,964	0	1,370,778

LINE 39 - DESCRIPTION	SALARY	SUPPLIES	OTHER	TOTAL
PHARMACY	227,011	467,098		694,109
IV THERAPY				0
CENTRAL (LESS DIAPERS)				0
	227,011	467,098	0	694,109

MEMORIAL CARE CENTER
ID # 0003103
Rental Amount for Movable Equipment
12/31/14

XII. RENTAL COSTS

B 16.

Item	Cost
Overlay Rentals (Mattresses&Cushions)	10,285.93
Vacuums & Canisters	47,781.07
Omnicell cabinets	44,421.00
Wheelchair/Knee walker Rentals	105.00
Equipment Rental	102,593.00

MEMORIAL CARE CENTER
PAGE 6, SCH VII RELATED PARTIES
12/31/14

SCH V LINE#		PG 8,Pt VIII LN #	COL 4 AMOUNT	COL 7 AMOUNT	COL 8 AMOUNT
22	EMPLOYEE BENEFITS- w/s B, ln 44	1	1,063,449	1,369,438	305,989
22	EMPLOYEE BENEFITS- w/s B, ln 50.01	1	0	3,518	3,518
22	EMP BENEFITS/CAFETERIA	12	0	77,471	77,471
	TOTAL TO PG 6,LINE 1		1,063,449	1,450,427	386,978
17	ADMINISTRATIVE		36,188	116,904	80,716
19	PROFESSIONAL SERVICES		5,800	5,800	0
20	DUES,FEES,ETC		5,962	5,962	0
21	CLERICAL & GENERAL *		71,902	882,544	810,642
24	TRAVEL AND SEMINAR		0	0	0
26	INSURANCE		65,788	65,788	0
	TOTAL TO PG 6,LINE 2	2-6	185,640	1,076,998	891,358
5	HEAT & OTHER UTILITIES		85,473	85,473	0
6	MAINTENANCE		133,207	166,636	33,429
	TOTAL TO PG 6,LINE 3	7	218,680	252,109	33,429
4	LAUNDRY		48,353	84,299	35,946
	TOTAL TO PG 6,LINE 5	8	48,353	84,299	35,946
3	HOUSEKEEPING- MCC	10	136,965	252,039	115,074
	HOUSEKEEPING- HOSPITAL	9	0	0	0
	TOTAL TO PG 6,LINE 5		136,965	252,039	115,074
1	DIETARY		443,274	598,530	155,256
2	FOOD PURCHASE		302,913	302,913	0
	TOTAL TO PG 6,LINE 6	11	746,187	901,443	155,256

* COL 7 ADMIN = COMMUNICATIONS, DATA PROCESSING,MATERIALS MGT, PATIENT ACCOUNT AND ADMIN

39	PHARMACY & IV THERAPY	18	694,109	1,144,682	450,573
39	MEDICAL SUPPLIES SOLD	19	0	0	0
	TOTAL TO PG 6,LINE 7		694,109	1,144,682	450,573

43	RADIOLOGY	15	16,838	12,829	(4,009)
43	LABORATORY	16	151,765	262,935	111,170
43	NUTRITIONAL SUPPORT	17	0	0	0
43	EKG	17	3,263	6,809	3,546
	TOTAL TO PG 6,LINE 8		171,866	282,573	110,707

10a	RESPIRATORY CARE	20	2,704	175,275	172,571
10a	PHYSICAL THERAPY	21	712,636	1,713,640	1,001,004
10a	OCCUPATIONAL THERAPY	22	398,919	937,154	538,235
10a	SPEECH THERAPY	23	158,875	351,214	192,339
	TOTAL TO PG 6,LINE 11		1,273,134	3,177,283	1,904,149

ALLOCATION OF COST
PAGE 8 SCH VIII
COST FROM ADJUSTED HCFA 2552, W/S B PART I, PART II
12/31/14

COST CENTER	(1) W/S B PART I TOTAL COST	(2)	(3) W/S B PART II CAPITAL COST	(4) NET OPERATING COST	(5) SNF REV AS % OF TOTAL REV	(6) W/S B PART I TOTAL SNF COST	LINE 44 (7)	W/S B PART II CAPITAL COST	(8) SNF ALLOCATED CAPITAL COST	(9) W/S B PT I NET OPERATING COST-SNF
EMPLOYEE BENEFITS	36,407,092		14,065	36,393,027		1,369,438		528	567	1,368,910
COMMUNICATION	713,309		117,586	595,723		13,700		2,258	2,426	11,442
DATA PROCESSING	10,234,986		4,820,591	5,414,395		220,052		103,643	111,340	116,409
MATERIALS MGT	967,798		188,183	779,615		19,000		3,694	3,968	15,306
PATIENT ACCOUNTS	4,627,351		202,161	4,425,190		26,036		1,135	1,219	24,901
ADMIN & GENERAL	30,832,135		893,324	29,938,811		936,064		27,124	29,138	908,940
PLANT CC	313,406		24,791	288,615		273,765		21,656	23,264	252,109
LAUNDRY	1,075,202		23,657	1,051,545		86,195		1,896	2,037	84,299
HOUSEKEEPING	3,898,581		154,084	3,744,497		0		0	0	0
HOUSEKEEPING CC	293,792		16,953	276,839		267,473		15,434	16,580	252,039
DIETARY	3,663,578		202,898	3,460,680		954,756		53,313	57,272	901,443
CAFETERIA	1,594,015		185,193	1,408,822		87,655		10,184	10,940	77,471
CENTRAL SUPPLY	1,581,755		213,283	1,368,472		18,703		2,522	2,709	16,181
PHARMACY	7,607,003		202,130	7,404,873		19,729		524	563	19,205
MEDICAL RECORDS	4,270,136		262,533	4,007,603		72,592		4,463	4,794	68,129
SOCIAL SERVICE	1,330,266		76,130	1,254,136		159,337		9,119	9,796	150,218
DEPR. BLDG MCC	755,018			755,018		488,074		0	0	488,074
DEPR. EQUIP MCC & HOSP	10,706,298			10,706,298		102,497		0	0	102,497
	120,871,721	0	7,597,562	113,274,159		5,115,066	0	257,493	276,616	4,857,573
EMPLOYEE BENEFITS - MEDICAL DIRECTOR					Ln 50.01	3,518	0	0	0	3,518
ANCILLARY COSTS: (COL 24)										
RADIOLOGY	9,608,204		1,386,469	8,221,735	0.00156	14,992	0	2,163	2,324	12,829
DRUGS & IV THERAPY	16,453,779		243,271	16,210,508	0.07061	1,161,860	0	17,178	18,454	1,144,682
RESPIRATORY THERAPY	4,228,388		206,369	4,022,019	0.04358	184,269	0	8,993	9,661	175,275
OCCUPATIONAL THERAPY	1,577,339		67,222	1,510,117	0.62058	978,871	0	41,717	44,815	937,154
SPEECH THERAPY	863,818		44,707	819,111	0.42877	370,383	0	19,169	20,593	351,214

EKG	3,485,038		343,808	3,141,230	0.00217	7,554	0	745	801	6,809
MEDICAL SUPPLIES SOLD	12,427,338		251,593	12,175,745	0.00000	0	0	0	0	0
LABORATORY	16,136,005		751,804	15,384,201	0.01709	275,784	0	12,849	13,804	262,935
PHYSICAL THERAPY	8,377,549		417,236	7,960,313	0.21527	1,803,459	0	89,820	96,490	1,713,640
	73,157,458	0	3,712,479	69,444,979		4,797,173	0	192,635	206,942	4,604,538
TOTAL COSTS	194,029,179	0	11,310,041	182,719,138		9,915,757	0	450,128	483,558	9,465,629

CAPITAL TO PG 8,LINE 30 11,310,041 483,558