

Facility Name & ID Number Memorial Convalescent Center

0003103 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,881		19,578	23,459	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	3,881		19,578	23,459	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.51%

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)

Nne

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

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

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 108 and days of care provided 11,652

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	381,090	2,400		383,490		383,490	299,879	683,369		1
2	Food Purchase		261,099		261,099		261,099		261,099		2
3	Housekeeping	87,021	12,306		99,327		99,327	49,532	148,859		3
4	Laundry		61,921		61,921		61,921	63,347	125,268		4
5	Heat and Other Utilities			73,367	73,367	(923)	72,444		72,444		5
6	Maintenance	53,128	8,012		61,140		61,140	25,904	87,044		6
7	Other (specify):*										7
8	TOTAL General Services	521,239	345,738	73,367	940,344	(923)	939,421	438,662	1,378,083		8
	B. Health Care and Programs										
9	Medical Director					6,423	6,423		6,423		9
10	Nursing and Medical Records	2,677,300	252,663	20,196	2,950,159	(9,592)	2,940,567	76,606	3,017,173		10
10a	Therapy	588,424	18,639		607,063		607,063	439,240	1,046,303		10a
11	Activities	83,083	3,956		87,039		87,039		87,039		11
12	Social Services	73,759			73,759		73,759	104,968	178,727		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Disposable Diapers		18,937		18,937	11,274	30,211		30,211		15
16	TOTAL Health Care and Programs	3,422,566	294,195	20,196	3,736,957	8,105	3,745,062	620,814	4,365,876		16
	C. General Administration										
17	Administrative	35,110			35,110	(6,423)	28,687		28,687		17
18	Directors Fees										18
19	Professional Services			7,713	7,713		7,713		7,713		19
20	Dues, Fees, Subscriptions & Promotions			5,664	5,664		5,664		5,664		20
21	Clerical & General Office Expenses	58,690		10,689	69,379	(759)	68,620	677,511	746,131		21
22	Employee Benefits & Payroll Taxes			764,515	764,515		764,515	315,928	1,080,443		22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			62,376	62,376		62,376		62,376		26
27	Other (specify):* Bad Debts			36,652	36,652		36,652	(36,652)			27
28	TOTAL General Administration	93,800		887,609	981,409	(7,182)	974,227	956,787	1,931,014		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,037,605	639,933	981,172	5,658,710		5,658,710	2,016,263	7,674,973		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 Convalescent Center

#0003103

Report Period Beginning: 01/01/2006 Ending: 12/31/2006

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			155,472	155,472		155,472	196,500	351,972			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			155,472	155,472		155,472	196,500	351,972			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	93,578	356,960		450,538		450,538	317,400	767,938			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):*	68,871	46,951	9,340	125,162		125,162	70,029	195,191			43
44	TOTAL Special Cost Centers	162,449	403,911	68,632	634,992		634,992	387,429	1,022,421			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,200,054	1,043,844	1,205,276	6,449,174		6,449,174	2,600,192	9,049,366			45

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

Memorial Convalescent Center

ID# 0003103

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	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 Convalescent Center

0003103

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	299,879	0	0	0	0	0	0	0	0	0	299,879	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	49,532	0	0	0	0	0	0	0	0	0	49,532	3
4	Laundry	0	63,347	0	0	0	0	0	0	0	0	0	63,347	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	25,904	0	0	0	0	0	0	0	0	0	25,904	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	438,662	0	0	0	0	0	0	0	0	0	438,662	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	76,606	0	0	0	0	0	0	0	0	0	76,606	10
10a	Therapy	0	439,240	0	0	0	0	0	0	0	0	0	439,240	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	104,968	0	0	0	0	0	0	0	0	0	104,968	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 Program	0	620,814	0	0	0	0	0	0	0	0	0	620,814	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	677,511	0	0	0	0	0	0	0	0	0	677,511	21
22	Employee Benefits & Payroll Taxes	0	315,928	0	0	0	0	0	0	0	0	0	315,928	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):*	(36,652)	0	0	0	0	0	0	0	0	0	0	(36,652)	27
28	TOTAL General Administration	(36,652)	993,439	0	0	0	0	0	0	0	0	0	956,787	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(36,652)	2,052,915	0	0	0	0	0	0	0	0	0	2,016,263	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Memorial Convalescent Center# 0003103

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

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	(992)	197,492	0	0	0	0	0	0	0	0	0	196,500	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	(992)	197,492	0	0	0	0	0	0	0	0	0	196,500	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	317,400	0	0	0	0	0	0	0	0	0	317,400	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	70,029	0	0	0	0	0	0	0	0	0	70,029	43
44	TOTAL Special Cost Centers	0	387,429	0	0	0	0	0	0	0	0	0	387,429	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(37,644)	2,637,836	0	0	0	0	0	0	0	0	0	2,600,192	45

Facility Name & ID Number Memorial Convalescent Center

0003103

Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
1	V	22	Employee Benefits	\$ 764,515	Memorial Hospital	0.00%	\$ 1,080,443	\$ 315,928	1
2	V	21	Administration	173,060			850,571	677,511	2
3	V	6	Maintenance	133,584			159,488	25,904	3
4	V	4	Laundry	61,921			125,268	63,347	4
5	V	3	Housekeeping	99,327			148,859	49,532	5
6	V	1	Dietary	644,589			944,468	299,879	6
7	V	15	Central	30,211			30,211		7
8	V	39	Pharmacy, Medical Supplies	450,538			767,938	317,400	8
9	V	43	Ancillary Services	125,162			195,191	70,029	9
10	V	12	Social Service	73,759			178,727	104,968	10
11	V	10	Medical Records	1,682			78,288	76,606	11
12	V	10a	Therapy	607,063			1,046,303	439,240	12
13	V	30	Depreciation	155,472			352,964	197,492	13
14	Total			\$ 3,320,883			\$ 5,958,719	\$ * 2,637,836	14

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

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 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 Convalescent Center# 0003103 Report Period Beginning: 01/01/2006 Ending: 2/31/2006

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	22	Emp Ben - Nursing & Med Dir	Salaries	77,746,091	2	\$ 28,352,145	\$ 639,534	2,751,933	\$ 1,003,564	1
2	21	Patient Accounts	Revenue	462,068,078	2	3,240,160	1,142,760	3,971,010	27,846	2
3	21	Communications	Phones	1,359	2	491,208	202,104	24	8,675	3
4	21	Data Processing	Resources	9,999	2	2,570,146	678,049	70	17,993	4
5	21	Materials Management	Stores Requisitions	4,858,478	2	1,265,013	616,743	112,209	29,216	5
6	21	Administration	Accumulated Cost	162,256,510	2	29,163,037	4,136,146	4,266,531	766,841	6
7	6	Plant	Square Feet	18,453	2	182,582	53,128	16,119	159,488	7
8	4	Laundry	Pounds	2,159,796	2	1,095,738	395,149	246,914	125,268	8
9	3	Housekeeping	Hours of Service	110,574	2	2,729,569	1,408,977	121	2,987	9
10	3	Housekeeping MCC	Square Feet	17,705	2	160,225	87,021	16,119	145,872	10
11	1	Dietary	Patient Meals	238,678	2	3,203,088	1,564,450	70,377	944,468	11
12	22	Emp Ben - Cafeteria	Employee Meals	154,167	2	1,401,511	483,510	8,199	74,536	12
13	10	Medical Records	Time Spent	10,000	2	4,605,180	1,949,842	170	78,288	13
14	12	Social Service	Time Spent	1,455,450	2	932,561	508,761	278,940	178,727	14
15	43	Radiology	Revenue	103,832,956	2	14,866,247	3,359,637	184,164	26,368	15
16	43	Laboratory	Revenue	75,819,504	2	14,388,796	4,045,928	650,578	123,465	16
17	43	Nutritional Support	Revenue	833,053	2	572,303	221,709	52,358	35,970	17
18	43	EKG	Revenue	19,671,827	2	3,378,720	1,085,087	54,657	9,388	18
19	39	Drugs & IV Therapy	Revenue	38,246,932	2	11,563,907	2,124,338	1,679,815	507,890	19
20	39	Medical Supplies Sold	Revenue	499,856	2	1,896,372	485,190	76,508	290,259	20
21	10a	Respiratory Care	Revenue	24,358,068	2	3,753,245	1,758,462	527,171	81,230	21
22	10a	Physical Therapy	Revenue	17,717,117	2	6,386,580	3,151,654	1,885,754	679,767	22
23	10a	Occupational Therapy	Revenue	2,411,898	2	605,406	323,165	1,082,068	271,608	23
24	10a	Speech Therapy	Revenue	155,829	2	123,145	62,482	17,334	13,698	24
25	TOTALS					\$ 136,926,884	\$ 30,483,826		\$ 5,603,412	25

Facility Name & ID Number Memorial Convalescent Center

0003103 Report Period Beginning: 01/01/2006 Ending: 2/31/2006

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	30	Capital Costs	See Attached	14,146,656	\$ 14,146,656	\$	352,964	\$ 352,964	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				\$ 14,146,656	\$		\$ 352,964	25

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 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	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 Convalescent Center# 0003103 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2005 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 2006 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:	2001	_____	8	
	2002	_____	9	
	2003	_____	10	
	2004	_____	11	
	2005	_____	12	
	FOR BHF USE ONLY			
	13	FROM R. E. TAX STATEMENT FOR 2005	\$	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:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
- 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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Memorial Convalescent 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 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
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 & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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 Convalescent Center

0003103 Report Period Beginning:

01/01/2006 Ending:

12/31/2006

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

Facility Name & ID Number Memorial Convalescent Center

0003103

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	108		1964	1964	\$ 882,395	\$ 847		\$	(\$47)	\$ 882,395	4
5			1966		144,150	189			(189)	144,150	5
6			1979		237,657	1,582	20.28	1,582		224,061	6
7			1980		2,695					2,695	7
8			1981		18,583					18,583	8
	Improvement Type**										
9		Electrical Upgrade		1996	25,549	1,359		1,359		14,267	9
10		Walking Track		1998	7,690	512	15	512		4,360	10
11		Roof Replacement		1998	68,383	6,838	10	6,838		58,126	11
12		Change in Electrical power system		1998	5,479	366	15	366		3,103	12
13		7 1/2 ton AC unit		1998	14,326	955	15	955		8,118	13
14		Air furnace		1998	15,226	1,015	15	1,015		8,628	14
15		5 ton air handler		1998	14,900	993	15	993		8,443	15
16		Electrical work-boiler room, AC unit,relamp, auto tr switch		1998	91,162	4,557	20	4,557		38,741	16
17		Air handling unit installed		1994	12,048	803	15	803		10,040	17
18		Repair parking lot		1994	83,569	2,785	10.85	2,785		74,139	18
19		Landscaping		1994	4,200	280	15	280		3,500	19
20		Flooring replaced patient room		1993	56,883	3,792	15	3,792		51,198	20
21		Activity Therapy renovation		1993	41,940	2,262	12.83	2,262		35,596	21
22		Condensing unit		1993	4,684	312	15	312		4,216	22
23		Air conditioners		1993	6,589	440	15	440		5,929	23
24		Upgrade lighting		1993	4,516	226	20	226		3,051	24
25		Renovate patient room & nurse station		1992	42,370	2,322	17.99	2,322		33,998	25
26		Renovate patient rooms-doors, wallcovering		1992	75,908	720	10.49	720		75,550	26
27		Roof top air conditioner		1992	4,342	289	15	289		4,198	27
28		Renovate business office		1991	35,387	1,437	18.5	1,437		31,010	28
29		Patient rooms-drywall,ceiling,paint		1991	39,835	1,262	14.55	1,262		39,835	29
30		Demolish back lounge		1991	752	25	15	25		752	30
31		Brickwork chimney		1991	5,225	174	15	174		5,225	31
32		Paint exterior tower		1991	1,185		5			1,185	32
33		ITE panel		1991	995	49	20	49		773	33
34		Air conditioners		1991	6,580	219	15	219		6,580	34
35		Telephone wiring		1991	924		10			924	35
36											36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number Memorial Convalescent Center

0003103

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)

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

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Circuit Breaker	1991	\$ 1,011	\$ 51	20	\$ 51		\$ 783	37
38	Cubicles & track	1990	9,899		5			9,899	38
39	Half glass door windows	1989	601		15			601	39
40	Roofing	1988	55,463		10			55,463	40
41	Air Conditioner	1998	1,556		5			1,556	41
42	Air Conditioner	1987	1,551		5			1,551	42
43	Remove bathroom showers	1987	17,966	464	15.56	464		17,733	43
44	Cooling units	1986	3,854		9			3,854	44
45	Cooling units	1985	5,644		10			5,644	45
46	Resurface road	1985	39,780		12			39,780	46
47	Guttering	1985	2,116		15			2,116	47
48	Metal door frames	1984	5,751		20			5,751	48
49	Water & sewer lines	1984	2,807		20			2,807	49
50	Sprinkler system	1978	27,578		19			27,578	50
51	Sprinkler system	1977	1,585		20			1,585	51
52	Cooling unit & heat detectors	1974	5,468		17.99			5,468	52
53	Air conditioners & beauty shop	1973	1,210		14.94			1,210	53
54	Heating & cooling equipment	1972	53,944		15.22			53,944	54
55	Smoke detector	1971	5,800		10			5,800	55
56	Land improvements	1968	4,238	7	40	51	44	4,238	56
57	Vinyl flooring restrooms	1999	2,441		5			2,441	57
58	Reznor make up air unit	1999	15,432	1,543	10	1,543		11,573	58
59	Electrical work	1999	2,566	128	20	128		960	59
60	New door physical therapy	2000	3,735	249	15	249		1,619	60
61	Porch columns	2000	5,965	397	15	397		2,587	61
62	Repair walls	2001	2,080	139	15	139		764	62
63	Electrical work	2001	4,191	209	20	209		1,154	63
64	Electrical work	2001	16,778	839	20	839		4,614	64
65	Window replacement	2002	113,345	7,557	15	7,557		34,006	65
66	Storage addition	2002	253,195	16,878	15	16,878		75,961	66
67	Storage addition	2002	4,227	845	5	845		3,805	67
68	Storage addition	2002	1,259		1			1,259	68
69	Fire Alarm/Nurse Call Replacement	2002	4,473	299	15	299		1,345	69
70	TOTAL (lines 4 thru 69)		\$ 2,633,636	\$ 66,215		\$ 65,223	\$ (992)	\$ 2,192,818	70

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

Facility Name & ID Number Memorial Convalescent Center

0003103

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,633,636	\$ 66,215		\$ 65,223	\$ (992)	\$ 2,192,818	1
2	Fire Alarm/Nurse Call Replacement	2002	350		3			350	2
3	Fire Alarm/Nurse Call Replacement	2002	1,001	201	5	201		900	3
4	Fire Alarm/Nurse Call Replacement	2002	48,125	4,812	10	4,812		21,655	4
5	Fire Alarm/Nurse Call Replacement	2002	490	33	15	33		148	5
6	Fire Alarm/Nurse Call Replacement	2002	61,775	3,089	20	3,089		13,896	6
7	Patient Wardrobe Units	2002	67,813	4,521	15	4,521		20,345	7
8	Patient Wardrobe Units	2002	5,824	582	10	582		2,621	8
9	Heating and Cooling Unit	2002	7,702	513	15	513		2,311	9
10	8" Faucets	2002	5,318	266	20	266		1,197	10
11	Window Replacement	2003	75	5	15	5		18	11
12	Storage Addition	2003	138	9	15	9		32	12
13	Fire Alarm/Nurse Call Replacement	2003	659	66	10	66		231	13
14	Window Replacement	2003	16,451	1,097	15	1,097		3,839	14
15	Patient Wardrobe Units	2003	16,789	839	20	839		2,937	15
16	Fire Alarm/Nurse Call Replacement	2003	19,745	987	20	987		3,455	16
17	Utility Storage Room Plumbing Work	2004	776	38	20	38		96	17
18	Beauty Shop/Utility Room Renovations	2004	4,626	231	20	231		578	18
19	Roof	2005	4,910	245	20	245		246	19
20	Rooftop Air Handler - 100 Hallway	2006	9,500	475	10	475		475	20
21	Doors	2006	6,500	325	10	325		325	21
22	Bell Tower Restoration	2006	6,935	231	15	231		6,935	22
23	Renovations - walls and ceilings	2006	22,329	744	15	744		744	23
24	Renovations - electrical	2006	19,033	476	20	476		476	24
25	Renovations - painting	2006	1,142	114	5	114		114	25
26	Renovations - fire dampers	2006	12,726	318	20	318		318	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,974,368	\$ 86,432		\$ 85,440	\$ (992)	\$ 2,277,060	34

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

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	\$ 370,249	\$ 48,214	\$ 48,214	\$		\$ 230,251	71
72	Current Year Purchases	386,865	20,826	20,826		8.6	20,826	72
73	Fully Depreciated Assets	223,251					223,251	73
74								74
75	TOTALS	\$ 980,365	\$ 69,040	\$ 69,040	\$		\$ 474,328	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	\$	\$	\$	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)	\$ 4,043,907	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 155,472	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 154,480	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (992)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,800,562	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 Convalescent Center

0003103

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 62,989 Description: See 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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		Contract	Total
		1 Drop-outs	2 Completed		
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.

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

	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	\$ 192,919		\$	\$ 3,981		\$ 196,900	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	hrs	350,097			4,348		354,445	4
5	Physician Care	10	visits		33	7,716		33	7,716	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescripts	93,578			356,960		450,538	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$ 636,594	33	\$ 7,716	\$ 365,289	33	\$ 1,009,599	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 Convalescent Center# 0003103Report Period Beginning: 01/01/2006Ending: 12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(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 <u>1,111,114</u>)	1,088,683		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,554		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,091,562	\$	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	2,849,435		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,024,641		16
17	Accumulated Depreciation (book methods)	(2,800,533)		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): <u>Land Improvements</u>	152,289		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,265,832	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,357,394	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 119,499	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	161,711		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)	\$ 281,210	\$	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	<u>Reserves for Self Insurance</u>	508,000		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 508,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 789,210	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,568,184	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,357,394	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,072,209	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,072,209	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(220,948)	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)	\$ (220,948)	17
	B. Transfers (Itemize):		
18	Interfund Transfer - Hospital	716,923	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 716,923	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,568,184	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Memorial Convalescent Center

0003103

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

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.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,971,010	1
2	Discounts and Allowances for all Levels	(3,964,634)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,376	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,985,155	6
7	Oxygen	527,171	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,512,326	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	1,679,815	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	650,578	19
20	Radiology and X-Ray	184,164	20
21	Other Medical Services	183,523	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,698,080	23
D. Non-Operating Revenue			
24	Contributions	11,003	24
25	Interest and Other Investment Income***	441	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 11,444	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)	\$ 6,228,226	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	940,344	31
32	Health Care	3,736,957	32
33	General Administration	981,409	33
B. Capital Expense			
34	Ownership	155,472	34
C. Ancillary Expense			
35	Special Cost Centers	575,700	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)*	\$ 6,449,174	40
41	Income before Income Taxes (line 30 minus line 40)**	(220,948)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (220,948)	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.

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Report Period Beginning: 01/01/2006

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12/31/2006

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,775	2,050	\$ 86,677	\$ 42.28	1
2	Assistant Director of Nursing	1,876	2,152	67,953	31.58	2
3	Registered Nurses	30,304	34,673	955,597	27.56	3
4	Licensed Practical Nurses	10,749	12,076	262,875	21.77	4
5	CNAs & Orderlies	68,625	77,355	983,657	12.72	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,264	5,161	83,083	16.10	10
11	Social Service Workers	2,792	3,295	73,759	22.39	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	30,219	35,159	381,090	10.84	15
16	Dishwashers					16
17	Maintenance Workers	3,104	3,528	53,128	15.06	17
18	Housekeepers	7,599	8,653	87,021	10.06	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator	251	300	28,687	95.62	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,892	21,583	377,549	17.49	24
25	Vocational Instruction	7,599	8,535	192,919	22.60	25
26	Academic Instruction					26
27	Medical Director	92	105	6,423	61.17	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	103	117	1,682	14.38	31
32	Other Health Care(specify)	22,109	25,881	557,954	21.56	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	210,353	240,623	\$ 4,200,054 *	\$ 17.45	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	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) <u>Physician Advisor</u>	59	7,200	Ln 10 Col 3	46
47			5,280	Ln 10 Col 3	47
48					48
49	TOTAL (lines 35 - 48)	59	\$ 12,480		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	154	\$ 9,043	Ln 10 Col 1	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	52	1,088	Ln 10 Col 1	52
53	TOTAL (lines 50 - 52)	206	\$ 10,131		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount
Joe Lanius	VP - Finance		\$ 11,188	Workers' Compensation Insurance	\$	IDPH License Fee	\$
Nancy Weston	VP - Nursing		17,499	Unemployment Compensation Insurance		Advertising: Employee Recruitment	
Dr. William Sutherland	Medical Director		6,723	FICA Taxes		Health Care Worker Background Check	
				Employee Health Insurance		(Indicate # of checks performed _____)	
				Employee Meals		Patient Background Checks	
				Illinois Municipal Retirement Fund (IMRF)*		Illinois Health Care	5,664
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 35,410				
B. Administrative - Other							
Description			Amount				
			\$			Less: Public Relations Expense	()
						Non-allowable advertising	()
						Yellow page advertising	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 5,664
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**	
Vendor/Payee	Type	Amount	Description	Line #	Amount	Description	Amount
Bell, Boyd & Lloyd, PLLC	Attorney Fees	\$ 3,413			\$	Out-of-State Travel	\$
B.K.D., LLP	Audit Fees	4,300					
						In-State Travel	
						Seminar Expense	
						Entertainment Expense	()
						(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 7,713	TOTAL	\$	TOTAL	\$

* Attach copy of IMRF notifications

**See instructions.

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? 8.6
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 30,211 Line 15
- (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. \$ 74,536 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,115,159
- (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 The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.