

		FOR BHF USE				

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0003103

Facility Name: Memorial Convalescent Center

Address: 4315 Memorial Drive Belleville 62226
 Number City Zip Code

County: St. Clair

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

HFS ID Number: 37-0635502-002

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

Type of Ownership:

<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Valorie Comley **Telephone Number:** (618)257-5613

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2007 to 12/31/2007 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) <u>Joe H. Lanius</u>	
	(Title) <u>Vice President - Finance</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) () _____ Fax # () _____	

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
 201 S. Grand Avenue East
 Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Memorial Convalescent Center

0003103 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	3,577		18,320	21,897	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	3,577		18,320	21,897	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 55.55%

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

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 10,765

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	381,529	2,400		383,929		383,929	266,285	650,214		1
2	Food Purchase		244,637		244,637		244,637		244,637		2
3	Housekeeping	96,307	15,581		111,888		111,888	45,701	157,589		3
4	Laundry		58,708		58,708		58,708	71,982	130,690		4
5	Heat and Other Utilities			85,436	85,436	(1,312)	84,124		84,124		5
6	Maintenance	56,973	6,801		63,774		63,774	17,864	81,638		6
7	Other (specify):*										7
8	TOTAL General Services	534,809	328,127	85,436	948,372	(1,312)	947,060	401,832	1,348,892		8
	B. Health Care and Programs										
9	Medical Director					6,144	6,144		6,144		9
10	Nursing and Medical Records	2,802,477	291,776	17,739	3,111,992	1,824	3,113,816	73,184	3,187,000		10
10a	Therapy	671,831	26,420		698,251		698,251	563,541	1,261,792		10a
11	Activities	76,610	5,847		82,457		82,457		82,457		11
12	Social Services	63,799			63,799		63,799	70,824	134,623		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,614,717	324,043	17,739	3,956,499	7,968	3,964,467	707,549	4,672,016		16
	C. General Administration										
17	Administrative	37,066			37,066	(6,144)	30,922		30,922		17
18	Directors Fees										18
19	Professional Services			4,300	4,300		4,300		4,300		19
20	Dues, Fees, Subscriptions & Promotions			5,664	5,664		5,664		5,664		20
21	Clerical & General Office Expenses	64,641		3,981	68,622	(512)	68,110	413,707	481,817		21
22	Employee Benefits & Payroll Taxes			828,173	828,173		828,173	269,704	1,097,877		22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			61,926	61,926		61,926		61,926		26
27	Other (specify):* Bad Debts			39,126	39,126		39,126	(39,126)			27
28	TOTAL General Administration	101,707		943,170	1,044,877	(6,656)	1,038,221	644,285	1,682,506		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,251,233	652,170	1,046,345	5,949,748		5,949,748	1,753,666	7,703,414		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: 01/01/2007 Ending: 12/31/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			172,938	172,938	172,938	37,606	210,544				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			172,938	172,938	172,938	37,606	210,544				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	126,495	352,341		478,836	478,836	312,996	791,832				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):*	62,397	43,827	9,378	115,602	115,602	152,864	268,466				43
44	TOTAL Special Cost Centers	188,892	396,168	68,670	653,730	653,730	465,860	1,119,590				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,440,125	1,048,338	1,287,953	6,776,416	6,776,416	2,257,132	9,033,548				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 Convalescent Center

0003103

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	(296)	30		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	(39,126)	27		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (39,422)		\$	30

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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	2,296,554		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 2,296,554		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 2,257,132		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	2	3	4	
		Yes	No	Amount	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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY					
48		49		50	
				51	
					52

Memorial Convalescent Center

ID# 0003103

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

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:

01/01/2007

Ending:

12/31/2007

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	266,285	0	0	0	0	0	0	0	0	0	266,285	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	45,701	0	0	0	0	0	0	0	0	0	45,701	3
4	Laundry	0	71,982	0	0	0	0	0	0	0	0	0	71,982	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	17,864	0	0	0	0	0	0	0	0	0	17,864	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	401,832	0	0	0	0	0	0	0	0	0	401,832	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	73,184	0	0	0	0	0	0	0	0	0	73,184	10
10a	Therapy	0	563,541	0	0	0	0	0	0	0	0	0	563,541	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	70,824	0	0	0	0	0	0	0	0	0	70,824	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	707,549	0	0	0	0	0	0	0	0	0	707,549	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	413,707	0	0	0	0	0	0	0	0	0	413,707	21
22	Employee Benefits & Payroll Taxes	0	269,704	0	0	0	0	0	0	0	0	0	269,704	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):*	(39,126)	0	0	0	0	0	0	0	0	0	0	(39,126)	27
28	TOTAL General Administration	(39,126)	683,411	0	0	0	0	0	0	0	0	0	644,285	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(39,126)	1,792,792	0	0	0	0	0	0	0	0	0	1,753,666	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Memorial Convalescent Center

0003103

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(296)	37,902	0	0	0	0	0	0	0	0	0	37,606	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	(296)	37,902	0	37,606	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	312,996	0	0	0	0	0	0	0	0	0	312,996	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	152,864	0	0	0	0	0	0	0	0	0	152,864	43
44	TOTAL Special Cost Centers	0	465,860	0	465,860	44								
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(39,422)	2,296,554	0	2,257,132	45								

Facility Name & ID Number Memorial Convalescent Center

0003103

Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	22 Employee Benefits	\$ 828,173	Memorial Hospital	0.00%	\$ 1,097,877	\$ 269,704
2	V	21 Administration	170,922			584,629	413,707
3	V	6 Maintenance	147,898			165,762	17,864
4	V	4 Laundry	58,708			130,690	71,982
5	V	3 Housekeeping	111,888			157,589	45,701
6	V	1 Dietary	628,566			894,851	266,285
7	V	39 Pharmacy,Medical Supplies	478,836			791,832	312,996
8	V	43 Ancillary Services	115,602			268,466	152,864
9	V	12 Social Service	63,799			134,623	70,824
10	V	10 Medical Records	1,824			75,008	73,184
11	V	10a Therapy	698,251			1,261,792	563,541
12	V	30 Depreciation	172,938			210,840	37,902
13	V						
14	Total		\$ 3,477,405			\$ 5,773,959	\$ * 2,296,554

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

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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: 01/01/2007

Ending: 2/31/2007

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	82568969	2	\$ 29,774,091	\$ 675,565	2,815,971	\$ 1,015,430	1
2	21	Patient Accounts	Revenue	543928022	2	3,596,097	1,267,865	4,014,988	26,544	2
3	21	Communications	Phones	1431	2	608,925	200,421	24	10,213	3
4	21	Data Processing	Resources	10000	2	2,792,655	711,659	70	19,549	4
5	21	Materials Management	Stores Requisitions	5115316	2	898,708	553,600	134,169	23,572	5
6	21	Administration	Accumulated Cost	174140040	2	19,666,560	3,792,844	4,469,371	504,750	6
7	6	Plant	Square Feet	18453	2	189,764	56,973	16,119	165,762	7
8	4	Laundry	Pounds	2197246	2	1,220,364	409,530	235,305	130,690	8
9	3	Housekeeping	Hours of Service	105282	2	2,752,198	1,527,534	0	0	9
10	3	Housekeeping MCC	Square Feet	17705	2	173,097	96,946	16,119	157,591	10
11	1	Dietary	Patient Meals	234971	2	3,200,804	1,613,806	65,691	894,851	11
12	22	Emp Ben - Cafeteria	Employee Meals	165935	2	1,569,069	575,113	8,444	79,846	12
13	10	Medical Records	Time Spent	10000	2	4,412,274	1,981,304	170	75,009	13
14	12	Social Service	Time Spent	1648580	2	936,916	546,032	236,880	134,623	14
15	43	Radiology	Revenue	116252906	2	14,102,837	3,602,172	196,029	23,781	15
16	43	Laboratory	Revenue	89618742	2	13,999,992	4,174,444	778,969	121,688	16
17	43	Nutritional Support	Revenue	15080	2	328,801	186,886	5,258	114,644	17
18	43	EKG	Revenue	23856363	2	3,319,045	1,152,037	59,971	8,344	18
19	39	Drugs & IV Therapy	Revenue	44326559	2	11,035,674	2,414,659	2,099,098	522,598	19
20	39	Medical Supplies Sold	Revenue	476689	2	2,370,830	542,669	54,133	269,232	20
21	10a	Respiratory Care	Revenue	26741164	2	3,700,560	1,834,030	708,479	98,042	21
22	10a	Physical Therapy	Revenue	19933876	2	6,097,852	3,314,612	2,304,498	704,955	22
23	10a	Occupational Therapy	Revenue	3196640	2	868,682	394,938	1,621,874	440,742	23
24	10a	Speech Therapy	Revenue	505976	2	275,698	157,590	33,132	18,053	24
25	TOTALS					\$ 127,891,493	\$ 31,783,229		\$ 5,560,509	25

Facility Name & ID Number Memorial Convalescent Center

0003103

Report Period Beginning: 01/01/2007

Ending: 2/31/2007

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	7,774,545	\$ 7,774,545	\$	210,840	\$ 210,840	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				\$ 7,774,545	\$		\$ 210,840	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.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 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 2006 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 2006.

(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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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:

01/01/2007 Ending:

12/31/2007

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:

01/01/2007 Ending: 12/31/2007

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	\$ 283		\$	\$ (283)	\$ 882,395	4
5			1966		135,504	63			(63)	135,504	5
6			1979		83,787	1,581	25	1,581		67,972	6
7											7
8											8
	Improvement Type**										
9		Electrical Upgrade		1996	25,549	1,356		1,356		15,621	9
10		Walking Track		1998	7,690	513	15	513		4,873	10
11		Roof Replacement		1998	68,383	6,839	10	6,839		64,964	11
12		Change in Electrical power system		1998	5,479	365	15	365		3,469	12
13		7 1/2 ton AC unit		1998	14,326	955	15	955		9,073	13
14		Air furnace		1998	15,226	1,015	15	1,015		9,643	14
15		5 ton air handler		1998	14,900	994	15	994		9,436	15
16		Electrical work-boiler room, AC unit,relamp, auto tr switch		1998	91,162	4,558	20	4,558		43,298	16
17		Air handling unit installed		1994	12,048	804	15	804		10,843	17
18		Repair parking lot		1994	83,569	2,782	10.85	2,782		76,924	18
19		Landscaping		1994	4,200	280	15	280		3,780	19
20		Flooring replaced patient room		1993	56,883	3,793	15	3,793		54,990	20
21		Activity Therapy renovation		1993	40,864	2,264	12.83	2,264		36,782	21
22		Condensing unit		1993	4,684	313	15	313		4,528	22
23		Air conditioners		1993	6,589	439	15	439		6,369	23
24		Upgrade lighting		1993	4,516	226	20	226		3,276	24
25		Renovate patient room & nurse station		1992	42,054	1,884	17.99	1,884		35,564	25
26		Renovate patient rooms-doors, wallcovering		1992	75,020	331	10.49	331		75,020	26
27		Roof top air conditioner		1992	4,342	145	15	145		4,342	27
28		Renovate business office		1991	34,447	1,058	18.5	1,058		30,747	28
29		Patient rooms-drywall,ceiling,paint		1991	39,029	100	14.55	100		38,681	29
30		Brickwork chimney		1991	5,225		15			5,225	30
31		Paint exterior tower		1991	1,185		5			1,185	31
32		ITE panel		1991	995	50	20	50		822	32
33		Air conditioners		1991	6,580		15			6,580	33
34		Circuit Breaker		1991	1,011	50	20	50		834	34
35		Cubicles & track		1990	9,899		5			9,899	35
36		Roofing		1988	55,463		10			55,463	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 Convalescent Center

0003103

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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	
37	Air Conditioner	1998	\$ 1,556	\$	5	\$	\$	\$ 1,556	37
38	Remove bathroom showers	1987	11,355	231	15.56	231		11,355	38
39	Land improvements	1968	2,170	4	40	54	50	2,169	39
40	Vinyl flooring restrooms	1999	2,441		5			2,441	40
41	Reznor make up air unit	1999	15,432	1,544	10	1,544		13,117	41
42	Electrical work	1999	2,566	128	20	128		1,088	42
43	New door physical therapy	2000	3,735	249	15	249		1,868	43
44	Porch columns	2000	5,965	398	15	398		2,984	44
45	Repair walls	2001	2,080	139	15	139		903	45
46	Electrical work	2001	4,191	210	20	210		1,363	46
47	Electrical work	2001	16,778	838	20	838		5,452	47
48	Window replacement	2002	113,345	7,558	15	7,558		41,564	48
49	Storage addition	2002	253,195	16,880	15	16,880		92,839	49
50	Storage addition	2002	4,227	423	5	423		4,227	50
51	Storage addition	2002	1,259		1			1,259	51
52	Fire Alarm/Nurse Call Replacement	2002	4,473	299	15	299		1,643	52
53	Fire Alarm/Nurse Call Replacement	2002	1,001	100	5	100		1,001	53
54	Fire Alarm/Nurse Call Replacement	2002	48,125	4,812	10	4,812		26,468	54
55	Fire Alarm/Nurse Call Replacement	2002	490	33	15	33		181	55
56	Fire Alarm/Nurse Call Replacement	2002	61,775	3,089	20	3,089		16,986	56
57	Patient Wardrobe Units	2002	67,813	4,521	15	4,521		24,866	57
58	Patient Wardrobe Units	2002	5,824	583	10	583		3,203	58
59	Heating and Cooling Unit	2002	7,702	514	15	514		2,824	59
60	8" Faucets	2002	5,318	266	20	266		1,463	60
61	Window Replacement	2003	75	5	15	5		23	61
62	Storage Addition	2003	138	9	15	9		41	62
63	Fire Alarm/Nurse Call Replacement	2003	659	66	10	66		297	63
64	Window Replacement	2003	16,451	1,097	15	1,097		4,936	64
65	Patient Wardrobe Units	2003	16,789	840	20	840		3,777	65
66	Fire Alarm/Nurse Call Replacement	2003	19,745	987	20	987		4,442	66
67	Utility Storage Room Plumbing Work	2004	776	38	20	38		134	67
68	Beauty Shop/Utility Room Renovations	2004	4,626	231	20	231		809	68
69	Roof	2005	4,910	246	20	246		614	69
70	TOTAL (lines 4 thru 69)		\$ 2,539,989	\$ 79,379		\$ 79,083	\$ (296)	\$ 1,985,995	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:

01/01/2007 Ending: 12/31/2007

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		\$ 2,539,989	\$ 79,379		\$ 79,083	\$ (296)	\$ 1,985,995	1
2	Rooftop Air Handler - 100 Hallway	2006	9,500	950	10	950		1,425	2
3	Doors	2006	6,500	650	10	650		975	3
4	Bell Tower Restoration	2006	6,935	462	15	462		693	4
5	Renovations - walls and ceilings	2006	22,329	1,489	15	1,489		2,233	5
6	Renovations - electrical	2006	19,033	952	20	952		1,428	6
7	Renovations - painting	2006	1,142	228	5	228		342	7
8	Renovations - fire dampers	2006	12,726	636	20	636		954	8
9	Doors	2007	7,033	352	10	352		352	9
10	Rooftop Air Handler	2007	9,500	238	20	238		238	10
11	Interior Doors	2007	9,508	476	10	476		476	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,644,195	\$ 85,812		\$ 85,516	\$ (296)	\$ 1,995,111	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 654,771	\$ 85,894	\$ 85,894	\$		\$ 238,939	71
72	Current Year Purchases	21,297	1,232	1,232		8.8	1,232	72
73	Fully Depreciated Assets	279,720					279,720	73
74								74
75	TOTALS	\$ 955,788	\$ 87,126	\$ 87,126	\$		\$ 519,891	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		2000 Ford Bus	2000	\$ 49,174	\$	\$	\$		\$ 49,174	76
77										77
78										78
79										79
80	TOTALS			\$ 49,174	\$	\$	\$		\$ 49,174	80

E. Summary of Care-Related Assets

	1	Reference	2	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$	3,689,157	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	172,938	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	172,642	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	(296)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	2,564,176	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: 01/01/2007

Ending: 12/31/2007

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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: \$ 73,331

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		3	4
		1	2		
		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.

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a	hrs	\$ 245,106		\$	\$ 7,439		\$ 252,545	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	hrs	368,519			3,210		371,729	4
5	Physician Care	10	visits		19	5,029		19	5,029	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescripts	126,495			352,341		478,836	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			\$ 740,120	19	\$ 5,029	\$ 362,990	19	\$ 1,108,139	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: 01/01/2007

Ending:

12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(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>1,496,058</u>)	1,382,413		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	627		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due from Medicare</u>	21,032		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,404,397	\$	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	2,515,456		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	996,663		16
17	Accumulated Depreciation (book methods)	(2,564,176)		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)	\$ 1,140,232	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,544,629	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 123,502	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	172,641		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)	\$ 296,143	\$	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>	558,004		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 558,004	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 854,147	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,690,482	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,544,629	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,568,184	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,568,184	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(138,807)	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)	\$ (138,807)	17
B. Transfers (Itemize):			
18	Interfund Transfer - Hospital	261,105	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 261,105	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,690,482	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Memorial Convalescent Center# 0003103Report Period Beginning: 01/01/2007Ending: 12/31/2007**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	\$ 4,014,988	1
2	Discounts and Allowances for all Levels	(5,240,347)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ (1,225,359)	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,959,504	6
7	Oxygen	708,479	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,667,983	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	2,099,098	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	778,969	19
20	Radiology and X-Ray	196,029	20
21	Other Medical Services	119,362	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 3,193,458	23
D. Non-Operating Revenue			
24	Contributions	1,520	24
25	Interest and Other Investment Income***	7	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,527	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)	\$ 6,637,609	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	949,011	31
32	Health Care	3,974,507	32
33	General Administration	1,026,229	33
B. Capital Expense			
34	Ownership	172,938	34
C. Ancillary Expense			
35	Special Cost Centers	594,439	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)*	\$ 6,776,416	40
41	Income before Income Taxes (line 30 minus line 40)**	(138,807)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (138,807)	43

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

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

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

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

Facility Name & ID Number Memorial Convalescent Center

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Report Period Beginning: 01/01/2007

Ending:

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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	1,729	2,062	\$ 87,464	\$ 42.42	1
2	Assistant Director of Nursing	1,819	2,144	71,497	33.35	2
3	Registered Nurses	34,585	38,389	1,132,552	29.50	3
4	Licensed Practical Nurses	8,800	9,939	219,312	22.07	4
5	CNAs & Orderlies	64,452	72,727	977,344	13.44	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,603	4,227	76,610	18.12	10
11	Social Service Workers	2,361	2,817	63,799	22.65	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	28,635	32,873	381,529	11.61	15
16	Dishwashers					16
17	Maintenance Workers	3,091	3,528	56,973	16.15	17
18	Housekeepers	7,881	9,560	96,307	10.07	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator	261	299	30,922	103.42	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,672	21,160	377,124	17.82	24
25	Vocational Instruction	9,163	10,183	245,107	24.07	25
26	Academic Instruction					26
27	Medical Director	89	106	6,144	57.96	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	104	118	1,824	15.46	31
32	Other Health Care(specify)	23,743	27,461	615,617	22.42	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	208,988	237,593	\$ 4,440,125 *	\$ 18.69	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>	57	7,200	Ln 10 Col 3	46
47			5,509	Ln 10 Col 3	47
48					48
49	TOTAL (lines 35 - 48)	57	\$ 12,709		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,275	\$ 69,463	Ln 10 Col 1	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	520	10,918	Ln 10 Col 1	52
53	TOTAL (lines 50 - 52)	1,795	\$ 80,381		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 Lanus	VP-Finance		\$ 12,060	Workers' Compensation Insurance	\$	IDPH License Fee	\$	
Nancy Weston	VP-Nursing		18,862	Unemployment Compensation Insurance		Advertising: Employee Recruitment		
Dr. William Sutherland	Medical Director		6,144	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.)			\$ 37,066					
B. Administrative - Other								
Description			Amount			Less: Public Relations Expense	()	
			\$			Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 5,664	
(Attach a copy of any management service agreement)								
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
B.K.D., LLP	Audit Fees		\$ 4,300			\$	Out-of-State Travel	\$
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	Entertainment Expense	()
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 4,300				(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Memorial Convalescent Center

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? 8.8
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 23,805 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 59,292
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 79,846 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,165,897
- (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? Not Applicable
Attach invoices and a summary of services for all architect and appraisal fees.