

Facility Name & ID Number Memorial Care Center

0003103 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	Private Pay	4 Other	Total	
8	SNF	2,366		18,052	20,418	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	2,366		18,052	20,418	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 51.80%

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 10,617

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: 12/31/2009 Fiscal Year: 12/31/2009

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

Facility Name & ID Number Memorial Care Center # 0003103 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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	390,847	2,400		393,247		393,247	228,817	622,064		1
2	Food Purchase		227,252		227,252		227,252		227,252		2
3	Housekeeping	98,952	21,380		120,332		120,332	52,380	172,712		3
4	Laundry		53,008		53,008		53,008	68,550	121,558		4
5	Heat and Other Utilities			75,688	75,688	(1,320)	74,368		74,368		5
6	Maintenance	70,770	4,064		74,834		74,834	27,946	102,780		6
7	Other (specify):*										7
8	TOTAL General Services	560,569	308,104	75,688	944,361	(1,320)	943,041	377,693	1,320,734		8
	B. Health Care and Programs										
9	Medical Director					7,620	7,620		7,620		9
10	Nursing and Medical Records	2,999,796	403,815	4,253	3,407,864	1,989	3,409,853	82,041	3,491,894		10
10a	Therapy	788,983	37,490		826,473		826,473	675,937	1,502,410		10a
11	Activities	72,173	6,442		78,615		78,615		78,615		11
12	Social Services	68,820			68,820		68,820	85,539	154,359		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,929,772	447,747	4,253	4,381,772	9,609	4,391,381	843,517	5,234,898		16
	C. General Administration										
17	Administrative	41,266			41,266	(7,620)	33,646		33,646		17
18	Directors Fees										18
19	Professional Services			6,125	6,125		6,125		6,125		19
20	Dues, Fees, Subscriptions & Promotions			5,664	5,664		5,664		5,664		20
21	Clerical & General Office Expenses	77,370		11,473	88,843	(669)	88,174	514,196	602,370		21
22	Employee Benefits & Payroll Taxes			905,069	905,069		905,069	441,469	1,346,538		22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			62,191	62,191		62,191		62,191		26
27	Other (specify):* Bad Debts			39,160	39,160		39,160	(39,160)			27
28	TOTAL General Administration	118,636		1,029,682	1,148,318	(8,289)	1,140,029	916,505	2,056,534		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,608,977	755,851	1,109,623	6,474,451		6,474,451	2,137,715	8,612,166		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

Memorial Care Center

#0003103

Report Period Beginning:

01/01/2009

Ending:

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			148,314	148,314		148,314	33,995	182,309			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			148,314	148,314		148,314	33,995	182,309			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	165,082	265,495		430,577		430,577	202,297	632,874			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):*	71,134	61,689	9,942	142,765		142,765	135,807	278,572			43
44	TOTAL Special Cost Centers	236,216	327,184	69,234	632,634		632,634	338,104	970,738			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,845,193	1,083,035	1,327,171	7,255,399		7,255,399	2,509,814	9,765,213			45

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

Memorial Care Center

ID# 0003103

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Memorial Care Center# 0003103

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	228,817	0	0	0	0	0	0	0	0	0	228,817	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	52,380	0	0	0	0	0	0	0	0	0	52,380	3
4	Laundry	0	68,550	0	0	0	0	0	0	0	0	0	68,550	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	27,946	0	0	0	0	0	0	0	0	0	27,946	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	377,693	0	0	0	0	0	0	0	0	0	377,693	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	82,041	0	0	0	0	0	0	0	0	0	82,041	10
10a	Therapy	0	675,937	0	0	0	0	0	0	0	0	0	675,937	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	85,539	0	0	0	0	0	0	0	0	0	85,539	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	843,517	0	0	0	0	0	0	0	0	0	843,517	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	514,196	0	0	0	0	0	0	0	0	0	514,196	21
22	Employee Benefits & Payroll Taxes	0	441,469	0	0	0	0	0	0	0	0	0	441,469	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):*	(39,160)	0	0	0	0	0	0	0	0	0	0	(39,160)	27
28	TOTAL General Administration	(39,160)	955,665	0	0	0	0	0	0	0	0	0	916,505	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(39,160)	2,176,875	0	0	0	0	0	0	0	0	0	2,137,715	29

STATE OF ILLINOIS

Facility Name & ID Number Memorial Care Center# 0003103

Report Period Beginning:

01/01/2009 Ending:

Summary B

12/31/2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	33,995	0	0	0	0	0	0	0	0	0	33,995	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	33,995	0	33,995	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	202,297	0	0	0	0	0	0	0	0	0	202,297	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	135,807	0	0	0	0	0	0	0	0	0	135,807	43
44	TOTAL Special Cost Centers	0	338,104	0	338,104	44								
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(39,160)	2,548,974	0	0	0	0	0	0	0	0	0	2,509,814	45

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	\$ 905,069	Memorial Hospital	0.00%	\$ 1,346,538	\$ 441,469	1
2	V	21 Administration	195,800			709,996	514,196	2
3	V	6 Maintenance	149,202			177,148	27,946	3
4	V	4 Laundry	53,008			121,558	68,550	4
5	V	3 Housekeeping	120,332			172,712	52,380	5
6	V	1 Dietary	620,499			849,316	228,817	6
7	V	39 Pharmacy, Medical Supplies	430,577			632,874	202,297	7
8	V	43 Ancillary Services	142,765			278,572	135,807	8
9	V	12 Social Service	68,820			154,359	85,539	9
10	V	10 Medical Records	1,989			84,030	82,041	10
11	V	10a Therapy	826,473			1,502,410	675,937	11
12	V	30 Depreciation	148,314			182,309	33,995	12
13	V							13
14	Total		\$ 3,662,848			\$ 6,211,822	\$ * 2,548,974	14

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

Facility Name & ID Number Memorial Care Center # 0003103 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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

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0003103

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

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	22	Emp Ben - Nursing & Med Dir	Salaries	2	\$ 37,354,460	\$ 863,057	3,047,778	\$ 1,250,649	1
2	21	Patient Accounts	Revenue	2	3,850,078	1,342,783	3,963,832	20,496	2
3	21	Communications	Phones	2	561,355	227,822	24	9,291	3
4	21	Data Processing	Resources	2	3,554,144	1,013,004	70	24,879	4
5	21	Materials Management	Stores Requisitions	2	893,267	560,767	171,009	28,114	5
6	21	Administration	Accumulated Cost	2	24,898,032	4,513,733	5,021,246	627,219	6
7	6	Plant	Square Feet	2	202,800	70,770	16,119	177,149	7
8	4	Laundry	Pounds	2	1,298,992	435,780	212,573	121,559	8
9	3	Housekeeping	Hours of Service	2	3,101,001	1,630,493	0	0	9
10	3	Housekeeping MCC	Square Feet	2	189,706	98,952	16,119	172,615	10
11	1	Dietary	Patient Meals	2	3,217,998	1,579,670	61,254	849,316	11
12	22	Emp Ben - Cafeteria	Employee Meals	2	1,883,882	668,421	8,930	92,761	12
13	10	Medical Records	Time Spent	2	4,942,944	2,029,874	170	84,030	13
14	12	Social Service	Time Spent	2	1,117,232	617,887	241,670	154,359	14
15	43	Radiology	Revenue	2	15,784,702	3,937,663	220,233	20,965	15
16	43	Laboratory	Revenue	2	16,197,782	4,647,266	1,109,238	153,422	16
17	43	Nutritional Support	Revenue	2	380,689	208,843	2,438	96,138	17
18	43	EKG	Revenue	2	31,481,019	1,235,006	96,552	8,047	18
19	39	Drugs & IV Therapy	Revenue	2	61,225,361	2,733,153	2,486,453	556,044	19
20	39	Medical Supplies Sold	Revenue	2	14,722,229	563,082	78,807	76,830	20
21	10a	Respiratory Care	Revenue	2	37,887,974	4,197,025	1,404,115	155,540	21
22	10a	Physical Therapy	Revenue	2	29,387,215	7,038,286	3,450,627	826,431	22
23	10a	Occupational Therapy	Revenue	2	4,228,349	1,022,932	2,065,348	499,654	23
24	10a	Speech Therapy	Revenue	2	851,770	378,791	46,738	20,785	24
25	TOTALS				\$ 162,734,488	\$ 35,582,724		\$ 6,026,293	25

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0003103

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01/01/2009

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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	8,710,954	\$ 8,710,954	\$	182,309	\$ 182,309	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				\$ 8,710,954	\$		\$ 182,309	25

Facility Name & ID Number

Memorial Care Center

0003103

Report Period Beginning:

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12/31/2009

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6		8	9	10									
					Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	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.)

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0003103

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

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:

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

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	\$		\$		\$ 882,395	4
5			1979		83,787	1,581	25	1,581		71,135	5
6											6
7											7
8											8
	Improvement Type**										
9		Electrical Upgrade		1996	25,549	1,355		1,355		18,335	9
10		Walking Track		1998	7,690	513	15	513		5,898	10
11		Roof Replacement		1998	68,383		10			68,383	11
12		Change in Electrical power system		1998	5,479	365	15	365		4,200	12
13		7 1/2 ton AC unit		1998	14,326	955	15	955		10,983	13
14		Air furnace		1998	15,226	1,015	15	1,015		11,673	14
15		5 ton air handler		1998	14,900	994	15	994		11,423	15
16		Electrical work-boiler room, AC unit,relamp, auto tr switch		1998	91,162	4,558	20	4,558		52,413	16
17		Air handling unit installed		1994	12,048	402	15	402		12,048	17
18		Repair parking lot		1994	83,569	1,638	10.85	1,638		81,346	18
19		Landscaping		1994	4,200	140	15	140		4,200	19
20		Flooring replaced patient room		1993	56,883		15			56,883	20
21		Activity Therapy renovation		1993	40,864	449	12.83	449		38,585	21
22		Condensing unit		1993	4,684		15			4,684	22
23		Air conditioners		1993	6,589		15			6,589	23
24		Upgrade lighting		1993	4,516	226	20	226		3,727	24
25		Renovate patient room & nurse station		1992	42,054	1,444	17.99	1,444		38,449	25
26		Renovate patient rooms-doors, wallcovering		1992	75,020		10.49			75,020	26
27		Roof top air conditioner		1992	4,342		15			4,342	27
28		Renovate business office		1991	34,447	1,058	18.5	1,058		32,862	28
29		Patient rooms-drywall,ceiling,paint		1991	39,029	100	14.55	100		38,880	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		921	32
33		Air conditioners		1991	6,580		15			6,580	33
34		Circuit Breaker		1991	1,011	50	20	50		935	34
35		Cubicles & track		1990	9,899		5			9,899	35
36		Land improvements		1968	2,170		40			2,170	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Memorial Care Center

0003103

Report Period Beginning:

01/01/2009 Ending: 12/31/2009

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	Vinyl flooring restrooms	1999	\$ 2,441	\$	5	\$	\$	\$ 2,441	37
38	Reznor make up air unit	1999	15,432	772	10	772		15,432	38
39	Electrical work	1999	2,566	128	20	128		1,345	39
40	New door physical therapy	2000	3,735	249	15	249		2,366	40
41	Porch columns	2000	5,965	398	15	398		3,779	41
42	Repair walls	2001	2,080	139	15	139		1,180	42
43	Electrical work	2001	4,191	210	20	210		1,782	43
44	Electrical work	2001	16,778	838	20	838		7,129	44
45	Window replacement	2002	113,345	7,556	15	7,556		56,677	45
46	Storage addition	2002	253,195	16,882	15	16,882		126,599	46
47	Storage addition	2002	4,227		5			4,227	47
48	Storage addition	2002	1,259		1			1,259	48
49	Fire Alarm/Nurse Call Replacement	2002	4,473	298	15	298		2,239	49
50	Fire Alarm/Nurse Call Replacement	2002	1,001		5			1,001	50
51	Fire Alarm/Nurse Call Replacement	2002	48,125	4,812	10	4,812		36,093	51
52	Fire Alarm/Nurse Call Replacement	2002	490	32	15	32		246	52
53	Fire Alarm/Nurse Call Replacement	2002	61,775	3,089	20	3,089		23,164	53
54	Patient Wardrobe Units	2002	67,813	4,522	15	4,522		33,908	54
55	Patient Wardrobe Units	2002	5,824	583	10	583		4,368	55
56	Heating and Cooling Unit	2002	7,702	514	15	514		3,851	56
57	8" Faucets	2002	5,318	266	20	266		1,995	57
58	Window Replacement	2003	75	5	15	5		33	58
59	Storage Addition	2003	138	9	15	9		59	59
60	Fire Alarm/Nurse Call Replacement	2003	659	66	10	66		429	60
61	Window Replacement	2003	16,451	1,097	15	1,097		7,130	61
62	Patient Wardrobe Units	2003	16,789	840	20	840		5,456	62
63	Fire Alarm/Nurse Call Replacement	2003	19,745	987	20	987		6,416	63
64	Utility Storage Room Plumbing Work	2004	776	38	20	38		210	64
65	Beauty Shop/Utility Room Renovations	2004	4,626	231	20	231		1,271	65
66	Roof	2005	4,910	246	20	246		1,105	66
67	Rooftop Air Handler - 100 Hallway	2006	9,500	950	10	950		3,325	67
68	Doors	2006	6,500	650	10	650		2,275	68
69	Bell Tower Restoration	2006	6,935	462	15	462		1,617	69
70	TOTAL (lines 4 thru 69)		\$ 2,359,046	\$ 63,762		\$ 63,762	\$	\$ 1,921,775	70

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

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		\$ 2,359,046	\$ 63,762		\$ 63,762	\$	\$ 1,921,775	1
2	Renovations - walls and ceilings	2006	22,329	1,489	15	1,489		5,211	2
3	Renovations - electrical	2006	19,033	952	20	952		3,332	3
4	Renovations - painting	2006	1,142	228	5	228		799	4
5	Renovations - fire dampers	2006	12,726	636	20	636		2,226	5
6	Doors	2007	7,033	703	10	703		1,758	6
7	Rooftop Air Handler	2007	9,500	475	20	475		1,188	7
8	Interior Doors	2007	9,508	951	10	951		2,378	8
9	Doors	2008	1,152	115	10	115		173	9
10	Renovations - Storage Room Electrical	2009	3,895	97	20	97		97	10
11	Renovations - Occup Therapy Construction	2009	16,906	564	15	564		564	11
12	Heating and Cooling Unit	2009	31,460	1,049	15	1,049		1,049	12
13	Renovations - painting/flooring Occup Therapy	2009	4,574	457	5	457		457	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)		\$ 2,498,304	\$ 71,478		\$ 71,478	\$	\$ 1,941,007	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	\$ 649,177	\$ 75,784	\$ 75,784			\$ 318,740	71
72	Current Year Purchases	8,721	1,051	1,051			1,051	72
73	Fully Depreciated Assets	319,501					319,501	73
74								74
75	TOTALS	\$ 977,399	\$ 76,835	\$ 76,835			\$ 639,292	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)	\$ 3,564,877	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 148,313	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 148,313	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,629,473	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions. YES NO

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

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

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

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

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: \$ 137,330 Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	21

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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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	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	\$ 279,201		\$	9,251		\$ 288,452	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	hrs	419,888			10,923		430,811	4
5	Physician Care		visits		9	1,670		9	1,670	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts	165,082			265,495		430,577	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	TOTAL			\$ 864,171	9	\$ 1,670	\$ 285,669	9	\$ 1,151,510	14

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

Facility Name & ID Number Memorial Care Center# 0003103Report Period Beginning: 01/01/2009Ending: 12/31/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009

(last day of reporting year)

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

		1	2	
		Operating	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>1,872,242</u>)	1,378,155		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	4,527		6
7	Other Prepaid Expenses	5,664		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due from Medicare</u>	38,162		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,426,833	\$	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	2,402,668		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,026,750		16
17	Accumulated Depreciation (book methods)	(2,629,473)		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>	95,459		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 935,404	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,362,237	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 138,102	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	213,929		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)	\$ 352,031	\$	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>	658,012		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 658,012	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,010,043	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,352,194	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,362,237	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,339,083	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,339,083	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	368,929	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)	\$ 368,929	17
	B. Transfers (Itemize):		
18	Interfund Transfer - Hospital	(355,818)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (355,818)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,352,194	24 *

* This must agree with page 17, line 47.

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	\$ 3,963,832	1
2	Discounts and Allowances for all Levels	(7,302,451)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ (3,338,619)	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,562,713	6
7	Oxygen	1,404,115	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 6,966,828	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	2,486,453	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,109,238	19
20	Radiology and X-Ray	220,233	20
21	Other Medical Services	177,796	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 3,993,720	23
D. Non-Operating Revenue			
24	Contributions	2,399	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,399	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)	\$ 7,624,328	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	943,041	31
32	Health Care	4,391,381	32
33	General Administration	1,140,029	33
B. Capital Expense			
34	Ownership	148,314	34
C. Ancillary Expense			
35	Special Cost Centers	573,342	35
36	Provider Participation Fee	59,292	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,255,399	40
41	Income before Income Taxes (line 30 minus line 40)**	368,929	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 368,929	43

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

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

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

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

Facility Name & ID Number **Memorial Care Center**

0003103

Report Period Beginning: **01/01/2009**

Ending:

12/31/2009

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	1,847	2,164	\$ 98,132	\$ 45.35	1
2	Assistant Director of Nursing	1,803	2,232	80,414	36.03	2
3	Registered Nurses	36,144	41,016	1,290,057	31.45	3
4	Licensed Practical Nurses	10,286	11,347	240,233	21.17	4
5	CNAs & Orderlies	63,783	72,297	987,419	13.66	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,179	3,851	72,173	18.74	10
11	Social Service Workers	2,433	2,883	68,820	23.87	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	26,828	30,669	390,847	12.74	15
16	Dishwashers					16
17	Maintenance Workers	3,110	3,528	70,770	20.06	17
18	Housekeepers	8,275	9,574	98,952	10.34	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator	263	301	33,646	111.78	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,952	19,300	378,922	19.63	24
25	Vocational Instruction	9,446	10,827	279,201	25.79	25
26	Academic Instruction					26
27	Medical Director	94	105	7,620	72.57	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	105	118	1,989	16.86	31
32	Other Health Care(specify)	26,874	30,625	745,998	24.36	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	211,422	240,837	\$ 4,845,193 *	\$ 20.12	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)				46
47			2,583	Ln 10 Col 3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 2,583		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	177	\$ 11,483	Ln 10 Col 1	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	2,651	55,623	Ln 10 Col 1	52
53	TOTAL (lines 50 - 52)	2,828	\$ 67,106		53

Facility Name & ID Number Memorial Care Center

0003103

Report Period Beginning: 01/01/2009 Ending: 12/31/2009

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Health Care \$5,664
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 6.2
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 27,590 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. \$ 92,761 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,197,051
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? None
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Not Applicable
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: BKD, LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Not applicable
Attach invoices and a summary of services for all architect and appraisal fees.